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ABSTRACT

Text of a Congressional hearing which examined the impact of outmoded means of financing health care on children and families of the United States and explored alternative systems that provide better care is provided in this document. An opening statement by Representative Bruce A. Morrison is presented and testimony by these witnesses is included: (1) Richard Holdt, vice president of marketing, Blue Cross/Blue Shield of Connecticut; (2) Lorraine V. Klerman, professor of public health, Department of Epidemiology and Public Health, School of Medicine, Yale University; (3) Leonard S. Krassner, president, Connecticut Chapter, American Academy of Pediatrics; (4) H. Craig Leroy, president, Insurance Association of Connecticut; (5) Theodore R. Marmor, professor of public policy and management, School of Organization and Management, Yale University; (6) Cornell Scott, president, Connecticut Primary Care Association and director, Hill Health Center; (7) Janet Spegele, vice president of legal department, Connecticut Business and Industry Association; (8) Kenneth E. Thorpe, director, Program on Health Care Financing and Insurance, Department of Health Policy and Management, School of Public Health, Harvard University; (9) Sister Anne Virginie, chairperson-elect, Connecticut Hospital Association and president, St. Raphael Healthcare System; and (10) Steven Wolfson, chairman, Health Systems Planning Committee, New Haven County Medical Association. Prepared statements and other materials by these witnesses are also included, as is a fact sheet appended to Representative Morrison's statement giving salient health care data and contrasting Canada's universal insurance system with the system employed in the United States. (ABL)

THE CHANGING FACE OF HEALTH CARE: THE MOVEMENT TOWARD UNIVERSAL ACCESS

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

HEARING HELD IN NEW HAVEN, CT, DEC. 11, 1989

Printed for the use of the
Select Committee on Children, Youth, and Families

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THE CHANGING FACE OF HEALTH CARE: THE MOVEMENT TOWARD UNIVERSAL ACCESS

MONDAY, DECEMBER 11, 1989

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The select committee met, pursuant to notice, at 9:46 a.m., in the Devaney Lecture Hall, Albertus Magnus College, Aquinas Hall, 700 Prospect Street, New Haven, Connecticut 06511-1189.

Members present: Representatives Morrison and Evans presiding.

Staff present: Jill Kagan, professional staff; and Dennis G. Smith, minority staff director.

Mr. MORRISON. I would like to call to order this field hearing of the House Select Committee on Children, Youth, and Families. I would especially like to welcome my colleague, Lane Evans, from Illinois here to New Haven. We are pleased to have the opportunity to look closely at the subject, "The Changing Face of Health Care: The Movement Toward Universal Access".

The Select Committee on Children, Youth, and Families is holding this hearing to examine the impact on children and families of the United States, outmoded means of financing health care and to explore alternative systems that provide better care.

I want particularly to thank our Chairman, George Miller, for authorizing this hearing, and the staff of the Select Committee on Children, Youth, and Families; especially Jill Kagan, for their excellent work in organizing the hearing. I also want to thank Janet Rozen and Stuart Gaul of my personal staff for their help as well.

Over the past few years, I have spent a great deal of time working with people here in Connecticut on this issue. I am happy to have the opportunity today to explore it further and to share some of what I have learned.

While today's hearing will focus on the problems of children and families, the failings of American health care have not been limited to these groups. All Americans now live with a "system" that is too bureaucratic, too expensive, and provides inadequate care to many people. Further, we are unwilling to recognize that we do not have a system so much as an enormous coincidence.

This leads us to try to resolve our problems by addressing the health care problems of only a portion of the population. This process of focusing on bits and pieces of our health care problems is driving this country toward a multi-tiered system of health care in which some go without needed care while others pay too much to

defray the cost of treating the uninsured. The most recent failure of this philosophy was the now-repealed Medicare Catastrophic Coverage Act of 1988. Although the population it targeted was very different from the one we will consider today, we have much to learn from its failure.

As long as we continue to take this band-aid approach to the issue, dealing with problems by tinkering with Medicare and Medicaid and private health insurance programs, we will continue to have inequities in the cost of and access to care. And we will continue to waste billions on needless paperwork and red tape. Developing an efficient and equitable plan for broad reform of our health care system is one of my highest goals. The United States is the only major industrialized nation without a national health care or health insurance system.

Over the last few years, I have met extensively with a Medical Advisory Committee, composed of a number of physicians from this area, to discuss exactly how we feel such a system should be structured. We have been particularly intrigued by the system of health insurance in place in Canada. Even a cursory look at the health of Canadians and Americans shows that Canada has a lower rate of infant mortality than does the United States. Also, the life expectancy of Canadian citizens is longer than that of Americans. Moreover, their better health is purchased at a lower cost. While the United States spends over 11 percent of our Gross National Product on health care, Canada spends only 7 to 8 percent of its GNP on the same function.

I am convinced that we need a system of universal health insurance similar to the one in place in Canada. Such a program should be provided as social insurance similar to the way that Social Security provides for death, disability, and retirement benefits. The financing system should be broad-based, progressive, and sufficient to sustain the program. Only in this way can we assure a base of support broad enough to make the program viable. The shortcomings of any other approach are apparent in the underfunding of Medicaid and the massive numbers of those eligible for such anti-poverty programs as WIC and Head Start who cannot be included because of underfunding caused by misplaced budget priorities.

The number of Americans who are in agreement with me is clearly on the increase. Constituents holding varied political beliefs are telling me that the time has come for a system of universal health insurance. One Midwestern Senator returning from the August recess told the Washington Post that 70 to 80 percent of the constituents with whom he spoke at town meetings supported a Canadian style system. Stories abound of small business owners who have faced crippling health insurance expenses after even one enormously expensive illness of an employee or the dependent of an employee. Executives of America's largest corporations, Lee Iacocca of Chrysler foremost among them, have stated that the cost of providing health coverage to employees, retirees, and dependents has harmed their companies' ability to compete in the international market place.

There is no question that the challenges of establishing such a universal system would be daunting, and that the system would be costly. However, there is no reason to assume that it would be

more expensive than our current ragtag approach. The lesson to be learned from our health care experiences over the last several years is that universal health insurance makes sense, not only for poor people or young people or families, but for all Americans.

Today, however, we will focus on the young. Our first panel will help us to understand the problems in access to health care faced by children in the United States, particularly those in Connecticut. This panel will also help us to understand why the cost of health care has increased so precipitously in this country over the last several years.

The second panel will offer the perspectives of the hospital and insurance industries on these problems and how to address them. We will also hear from the business community in Connecticut about how it has dealt with the cost of health insurance for its employees and their families.

Finally, we will hear about alternative systems. We will hear from Dr. Steve Wolfson about his work and the efforts of the Medical Advisory Committee; from Ted Marmor, one of the country's leading experts on the Canadian health insurance system; and from Dr. Leonard Krassner, the president of the Connecticut chapter of the American Academy of Pediatrics, who will discuss his organization's proposal to provide universal access to care to children and pregnant woman.

I am looking forward to talking with our witnesses today. We have much ground to cover.

[Opening statement of Congressman Bruce Morrison follows:]

OPENING STATEMENT OF HON. BRUCE A. MORRISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

The Select Committee on Children, Youth, and Families is holding this hearing to examine the impact on children and families of the United States' outmoded means of financing health care and to explore alternative systems that provide better care.

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THE CHANGING FACE OF HEALTH CARE: THE MOVEMENT TOWARD UNIVERSAL ACCESS

A FACT SHEET

MILLIONS OF AMERICANS, INCLUDING CHILDREN, LACK HEALTH COVERAGE

* In 1987, 37 million non-elderly Americans had no health insurance. Of these, more than 12 million were children, a 14% increase since 1981. [Swartz, 1989; American Academy of Pediatrics (AAP), 1989]

* Almost 3 out of 10 of the uninsured are "near-poor," those with family incomes between one and two times the poverty level.[1] More than half of uninsured children live in two-parent, white families where there is at least one full-time employed parent earning more than a poverty level income. (Swartz, 1989; AAP, 1989)

* Only 4 out of 10 people in poverty are covered by Medicaid. In 1986, almost half of all poor children were <u>not</u> covered by Medicaid, up from roughly one-third a decade earlier. [Swartz, 1989; National Association of Children's Hospitals and Related Institutions, Inc. (NACHRI), 1989]

* Twenty-six percent of women in their child-bearing years (15-44) have no health insurance coverage for maternity care; 17% of women in this age group have no insurance at all. Fifteen percent of women who deliver babies are not insured for maternity care. (AAP, 1989)

UNINSURED RECEIVE LESS HEALTH CARE AND ARE LESS HEALTHY

* The uninsured are nearly twice as likely as those with health insurance to lack a regular source of health care. They also have 27% fewer ambulatory visits and a slightly higher rate of medical emergencies. (Robert Wood Johnson Foundation, 1987)

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[1] In 1988, the federal poverty level was $12,092 for a family of 4.

* The uninsured are 33% more likely to be in fair or poor health than those with health insurance. (Freeman and Blendon, 1987)

* Uninsured low-income children receive 40-50% less physician and hospital care than insured children. (Rosenbaum, 1987)

* Babies whose parents have no health insurance are 30% more likely than those from insured families to die or be seriously ill at birth, according to a study of more than 100,000 births in the San Francisco Bay area. (Braveman, 1989)

UNINSURED IN CONNECTICUT RESEMBLE THE NATION

* Over 11%, or roughly 350,000, of Connecticut's residents, have no medical insurance. More than one-third (120,000) of these are children. [Health Systems Agency (HSA), 1988]

* Roughly three-quarters of Connecticut's medically uninsured are employed persons and their dependents. (HSA, 1988)

* About 20% of children in Connecticut ages 0-19 are insured, nearly twice the rate of residents over age 30 who are uninsured. (HSA, 1988)

* In 1987, blacks in Connecticut were over 50% more likely to be uninsured than were whites. (HSA, 1988)

FAMILIES BEAR BRUNT OF RISING HEALTH CARE COSTS

* National health expenditures amounted to $500 billion in 1987. Individuals incurred 42% ($200 billion) of all health services and supply cost. Over $123 billion of money spent by individuals was in the form of out-of-pocket expenditures, while $42 billion went toward premium payments. (Health Care Financing Administration, 1988; Matlin, 1989)

* Between 1984 and 1989, average per employee annual premiums more than doubled ($1,453 to $3,117). The percentage of surveyed companies paying 100% of the premium for family coverage dropped from 38% in 1984 to 32% in 1988. (Hay/-Higgens, 1989)

* On average, employers paid 83% of premiums in 1987. Only 5% of employees had first dollar coverage; 75% percent of employees had to pay a deductible and coinsurance of 20% or more. (DiCarlo and Gable, 1989)

* A Massachusetts study found that families earning 200% of poverty have little or no disposable income to spend on health insurance. If minimal child care expenses are taken into account, families were considered unable to contribute significantly to insurance premium costs until their income exceeded 300% of poverty. (Goldberger and Hegarty, 1989)

HEALTH CARE COSTS FOR CHILDREN HIGH AND INCREASING

* Between 1977 and 1987 total personal health care expenditures for children almost tripled from $19.5 billion to $52 billion. Of the $52 billion, 74% came from private sources, 17% from Medicaid, and the remaining 9% from all other public sources. (McManus, 1989)

* For children under 19, per capita health expenditures rose from $269 in 1977 to $745 in 1987, a 177% increase. (McManus, 1989)

CANADA'S UNIVERSAL INSURANCE SYSTEM LESS COSTLY THAN U.S.

* In 1987, estimated health care costs accounted for 8.6% of Canada's GNP, compared to more than 11% in the U.S. Between 1971 and 1987, health care costs as a percentage of GNP increased about 16% in Canada, compared to more than 44% in the U.S. (Evans, March 1989)

* Americans spend five times as much as Canadians to pay for the overhead component of health insurance. Nearly 15% of U.S. health expenditures go for administrative costs. (Evans, March 1989; Kosterlitz, July 1989)

* Between 1971 and 1985, the percentage of the U.S. GNP going to physicians increased more than 40%, compared to a 10% increase in Canada. (Evans, March 1989)

* According to Blue Cross of Ontario, it costs 67% more to take care of a broken leg in the U.S. than it does in Canada. (*Wall Street Journal*, 1988)

INFANT AND CHILD HEALTH IN THE U.S.

* Approximately 7 million U.S. children do not receive routine medical care. (NACHRI, 1989)

* Less than 60% of children under age 4 had received the complete basic series of immunizations in 1985, while cases of mumps, measles, and pertussis have risen. Only 37% of infants ages 0-1 are fully immunized against diphtheria, tetanus, and pertussis. [NACHRI, 1989; Office of Technology Assessment (OTA), 1987]

* Each year, nearly 40,000 infants die before their first birthday, representing a rate of 10.1 infant deaths per 1000 live births. The U.S. ranks last among 22 industrialized nations in its infant mortality rate. [National Center for Health Statistics (NCHS), 1989; U.S. Public Health Service (PHS), 1989]

INFANT AND CHILD HEALTH IN CANADA

* In 1985, Canada's infant mortality rate was 7.9 infant deaths per 1,000 live births. Canada ranks eighth among 22 industrialized nations in its infant mortality rate. (PHS, 1989)

* In Canada, 80% of children ages 0-1 are fully immunized against diphtheria, tetanus and pertussis. (OTA, 1987)

12/11/89

Mr. MORRISON. The gentleman from Illinois.

Mr. EVANS. Thank you, Mr. Chairman. I am very pleased to join you here in New Haven today. I come from a down state Illinois district of 14 counties, and many of the problems that you have outlined, we have also. And that is why I am pleased to talk about the need for universal access to health care.

In my district, we are having problems not only reaching indigent clients of health clinics, but also many of our farmers and people in rural areas who have no health care whatsoever, or very little health care, available to them. We have had problems with the rural differential in the ways that our hospitals are reimbursed for the provision of Medicare services.

With our farm crisis and the unemployment we are having and the farm implement manufacturers in my district—the John Deers and the Cases and even in the construction equipment manufacturers, Caterpillar, we have had unprecedented unemployment. Many of those people who have had health insurance, after six months of losing their jobs, no longer have that. They turn to the Veteran's Administration, many of them being veterans, and find that the Veteran's Administration has cut their health care programs, at least in the non-service connected area.

And I have had the opportunity to go to West Haven, Connecticut, VA hospital in the past at Congressman Morrison's invitation. I am a Chairman of the Veterans Affairs Committee, Subcommittee on Oversight and Investigations. It is a problem nationwide that we are having. And with the repeal of catastrophic health care, and the absence of any real long term home health care program, I think now we do need to look at it as more than a piece meal program that just benefits particular groups of people who need help. As a veteran myself, I think that this is a right that all Americans ought to have, not just people who happen to have perhaps a veteran's status or a senior citizen's age.

So, I am very pleased to join you to hear from these people. I have come to the conclusion that with us spending more of our gross national product on the delivery of medicine than virtually any other country that has national health care, it is time to take a new look at how we deliver health care in this country and how we pay for it. So, I am very pleased to join you and look forward to hearing from these witnesses.

Mr. MORRISON. Thank you very much. Prior to the convening of this hearing, the Committee and its staff had the opportunity to visit the Fair Haven Community Health Center. We learned about the particular problems of that center and the population which it serves and the special problems of the approximately 50 percent of individuals that they see who have no health insurance coverage.

I would like to enter into the record the Annual Report of the Fair Haven Health Clinic which describes some of the work that they are intending to do.

[Annual Report of the Fair Haven Community Health Center follows:]

FAIR

HAVEN

COMMUNITY

HEALTH

CENTER

ANNUAL

REPORT

1988-89

This report prepared by

KATRINA CLARK

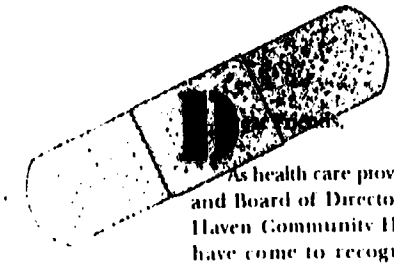
and

BETSY PERCOSKI

Design by PAUL KAZMERCIK

Photography by VIRGINIA BLAISDELL

Printing by THE HARTY PRESS, INC



As health care providers, the Staff and Board of Directors of the Fair Haven Community Health Center have come to recognize that our patients need more than just a simple "band-aid."

Katrina Clark, Director

Our campaign which will finance our expansion into the property at 372 Grand Avenue uses a "band-aid" graphic to emphasize the scope of care that we are called upon to deliver. "We Cover Fair Haven," the words imprinted over the picture of a bandaid, tell the complete story.

Serving the needs of the greater Fair Haven community, means providing midwives for mothers and their unborn children, pediatricians and nurse practitioners for young families; internists for adults and elderly; counselors and clinicians for teens at our local high school; and outreach and social workers for victims of urban stress and violence.

The addition of six new exam rooms, and new offices for social services will enable us to continue to broaden the scope of our services. For many of our patients, the Center is the only place where they seek medical care. At the Center, our patients are treated with the respect, and care, which is essential to building a pattern of trust with their health care providers. We treat entire families, and our definition of health care encompasses not just chronic and episodic illness, but their total well-being — physical and mental.

During 1989, we will need to call on the generosity of our friends to meet our goal of $500,000 for our new expansion. In the past, our contributors, staff, friends, volunteers, board members, funding sources and patients have demonstrated their support of our continuing work in Fair Haven, and for that, we thank them all.

We welcome your interest and support of the Fair Haven Health Center. If you would like additional information about our programs, or have any questions or comments, please call us.

Katrina Clark, MPH
Director

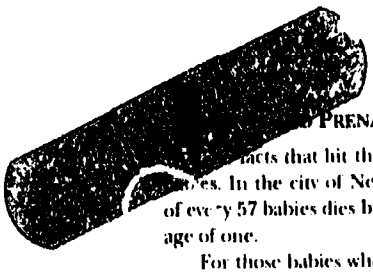
Amy Goldfarb, PhD
President, Board of Directors

Every child deserves a healthy start in life, and for these two sisters, Samantha and Shantoil Peace, they're getting just that at the Fair Haven Health Center. Elizabeth Magerkurth, FNP discusses their health with their mother Penelyn Epps.

The words of experts on the state of health care in our nation provide a bleak picture. Some 37 million Americans, 16% of our population, have no health-care insurance. Two thirds of these are the "working poor." They are employed in low paying jobs, and 12 million are children.

When the Fair Haven Community Health Clinic opened our doors as a free clinic housed in a neighborhood school seventeen years ago, there was a need for health care in this neighborhood of the city of New Haven. The need is greater today than it was when we began. The lives of the people we serve have become increasingly complicated with the problems which cut across the nation.

In this community, we have been able to make a difference. We are meeting the problems which affect our patients' health head-on. We take our programs to the people who need them and practice health care actively, emphasizing prevention and intervention. Lastly, we know our patients as people, not simple statistics.



Prenatal Care

facts that hit the hardest concern ...ves. In the city of New Haven, one out of eve ·y 57 babies dies before reaching the age of one.

For those babies who have a low birthweight, if they survive past their first birthday, they may still face long term physical and developmental problems. At the Fair Haven Health Center we know that prenatal care is the critical factor. Expectant mothers receive the office visits, nutrition counseling, social services and childbirth classes which they need to give birth to a healthy baby.

"A child born in Japan, Finland, Hong King, Ireland, Australia, Canada, Singapore or any of twelve other industrialized nations has a better chance of surviving his or her first year than a child born in the United State of America"

The National Commission to Prevent Infant Mortality

Each expectant mother has the benefit of a one-to-one relationship with a nurse midwife who provides care during the pregnancy, at the birth, and at a follow-up visit at the new mother's home. This is the kind of care that we know makes a difference. The Center staff provided prenatal care in 1988 to over 100 women. Women with high-risk medical conditions were referred to consulting obstetricians or one of New Haven's hospitals. Prenatal care is provided on-site at the Center, and births are at the Hospital of St. Raphael.

With new funding from the state of Connecticut through the Healthy Start program, the Center has been able to increase our social services and support programs for pregnant women.

The care a child receives in his or her first years can affect the rest of their life. In 1988, nearly 700 children age 5 and under were registered in our well baby program. Our pediatric and well-baby visits include physical exams, education, immunizations, and development assessments. Each is an important element in the health of a child, and we were able in 1988 to begin to provide more effective developmental assessments.

Development assessments allow us to identify at a very early age the need for speech, socialization skills, and physical therapy. A child as young as 6 months can be assessed by members of our staff who have received certification in Infant Development Assessment Training. In a series of three visits, which include meeting with parents, we assess whether a child might need a specialized program. In the past, our patients were referred to outside agencies and faced a waiting time of 1-2 years. Now in a matter of weeks, an assessment is completed and recommendations made which can be used by the staff as part of a child's routine care. As a result, these very young children are getting a better start on their lives.

Food is basic. It is basic to good health, and it is a basic need for many of the families we see. The children in our neighborhood

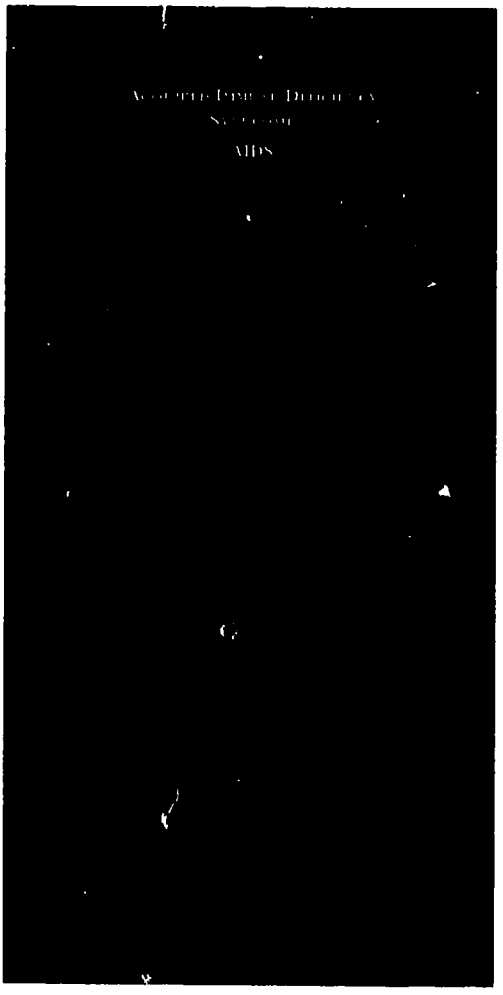
18 month old Chaylin Matta listens to Anne Somsel (l) and Maria Melendez (r) while her mother, Maura Matta looks on.

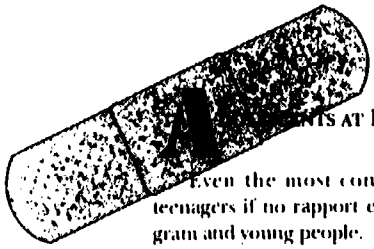
have the benefit of a school lunch, and breakfast program once they are of school age. But the Health Center is able to step in with the WIC (Women, Infants and Children) program to supplement pregnant women's and children's diets so a child has sound nutrition in those first critical years. Through the Center's program, women who are pregnant or breast-feeding are able to purchase nutritious food for themselves and their children under age 5 with food vouchers disbursed by the Center. Although the vouchers are for specific types of food such as milk, eggs, cheese, and juices, we recognize that handing out vouchers is not enough. Our staff first interviews the mother to make an nutritional assessment. Then we provide information on basic food groups, and even recipes for healthy meals. During 1988, we saw the need for this kind of program increase dramatically, from 820 to over 900 participants in WIC by the end of the year.

Even with the best possible programs in place, parents need to be able to reach a physician when their child is ill or injured. Since we feel strongly that parents need to know that there is someone to call at these times, we provide telephone coverage 24 hours a day, 7 days a week. A nurse practitioner or a physician answers calls, handles triage, and will refer patients to a hospital if needed.

Caring for children is a 24 hour a day job — for parents, and for the Fair Haven Health Center.

Sandra Wade meets with midwives Kate Mitchenall and Melissa Lonergan for a follow up visit after the birth of her baby

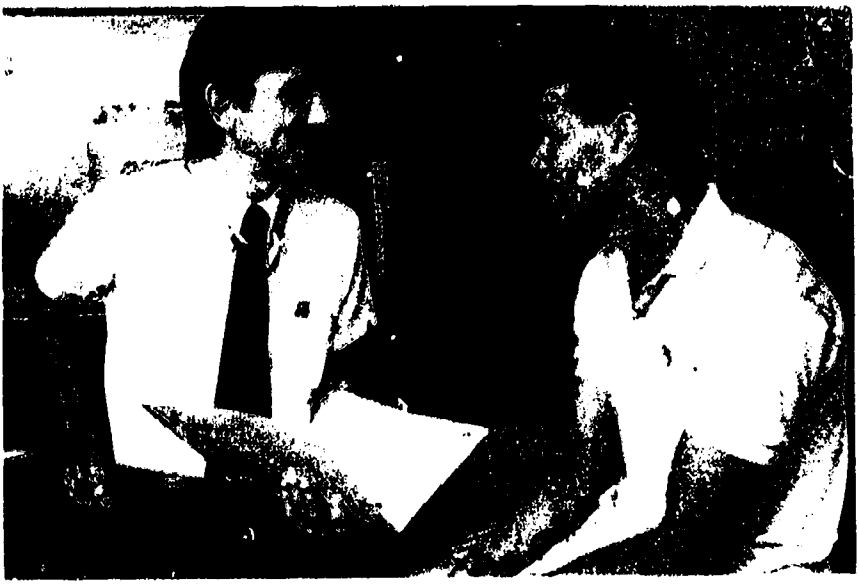

AIDS



...NTS AT RISK

Even the most comprehensive program will not help teenagers if no rapport exists between the providers of the program and young people.

Six years ago, the Fair Haven Health Center opened a satellite clinic at Wilbur Cross High School. The clinic, called The



Semeon Tsallums MD sees many of our adolescent patients. Here he is answering questions for 17year old Juan Reyes.

Body Shop, serves basic health needs such as physical exams, reproductive education and counseling, and information on drug and alcohol abuse. The Body shop was initially funded by a private foundation. Now, the State Department of Health Services (DOHS) funds the services and contracts with the Center through the New Haven Board of Education to provide the services for this unique program. During 1988, we increased The Body Shop's hours to five days a week, with pediatricians, nurse practitioners and social work staff available to the students and staff.

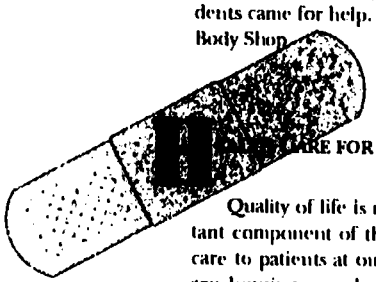
As The Body Shop gained acceptance among the students, and staff, at Wilbur Cross High School, we added programs on

AIDS and parenting skills. In addition, a Center program called "Body and Soul" was established to help teenagers who were recognized as potential dropouts. Body and Soul was funded by the U.S. Department of Health and Human Services in conjunction with the San Diego State University Foundation as a demonstration project. This past year, 1988-1989, was the final year of the project under the current funding. The staff of the Body and Soul project has concentrated on integrating this program into an ongoing social development program within the school itself.

A new project in 1988 saw the Center join forces with concerned teenagers to sponsor a Students Against Drunk Driving (SADD) chapter at Wilbur Cross High School. The Center has provided meeting space and direction to the group which is working to create a greater awareness of the problems of alcohol use among teenagers.

The Body Shop has continued to be our fastest growing program. We all hear about the troubles of adolescents today — teen pregnancy, drugs, alcoholism, but what we don't hear is the fact that teenagers want solutions too. They need help. When that help is readily available — at their own school — it can make a difference in their lives.

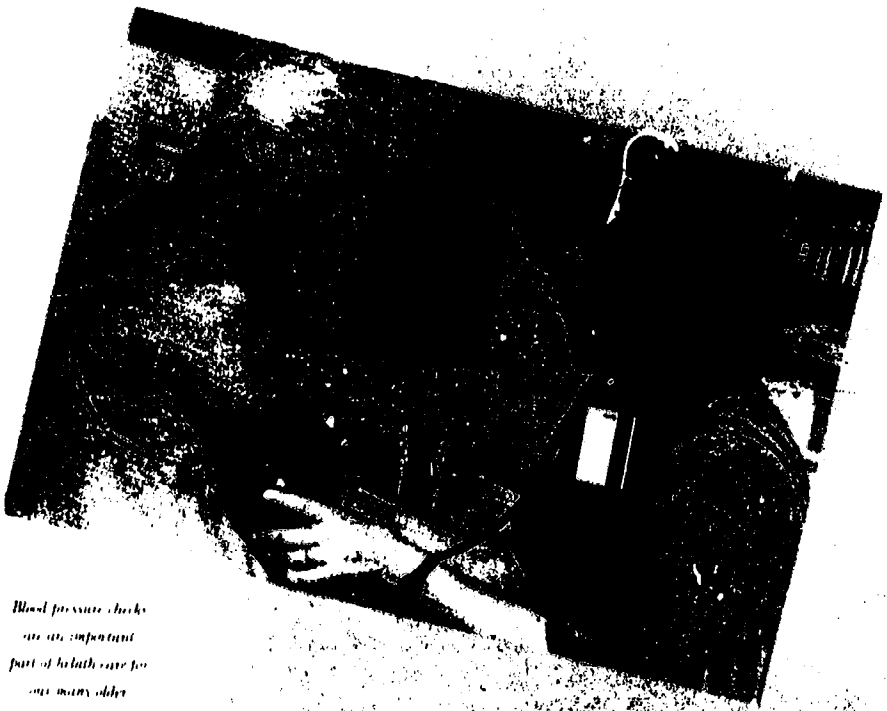
When The Body Shop opened its doors in 1982, 80 students came for help. Last year, there were over 800 visits to The Body Shop.



RE FOR AN AGING POPULATION

Quality of life is more than a handy phrase. It is an important component of the Center's approach to providing health care to patients at our Satellite Clinic at Bella Vista senior citizen housing complex. We have successfully been able to help many of our elderly patients continue to live independently in their apartments there, and forego the stress and financial burden of entering a nursing home. By closely monitoring their health, we enable these patients to successfully manage chronic illnesses and avoid debilitating conditions.

The Bella Vista Satellite consists of two parts. At Clinic I, residents of the housing complex can visit for blood pressure checks, individual counseling, exercise programs and discussions on health topics. In 1988, over 1,000 residents visited



Blood pressure checks are an important part of health care for our many older patients. Here Eli Weinstein, MD takes a routine reading for Vincent Crisanti.

Clinic I, which is staffed by a counselor/social workers, nurses and volunteer office assistants.

At Clinic II, residents receive full medical care from a staff of internists working with medical administrative assistants. In 1984, we expanded to peak capacity for our current staffing, with nearly 400 patients registered with our physicians for primary care at the Isola Vita Satellite. The need for this kind of health care — reliable, convenient and compassionate — will doubly increase in the years ahead as elderly patients seek to maintain independent living, and maintain their health.

HEALTH CARE – PAYING THE BILL

A patient at the Fair Haven Health Center may pay as little as $7 for a regular office visit, if their income and family situation places them at the low end of our sliding fee scale. This $7 fee does not come close to covering our cost for a single office visit.

For many of our patients, all their medical expenses must be paid "out of pocket." Of the patients at the Center, 10% have no medical insurance, compared to a Connecticut average of 11% medically uninsured. Only 35% of our income comes from patient fees.

The workers at our front desk are trained to help patients like Bienvenido Padua with the financial side of their health care. Candi Jennicelli and Charla Nash (r) can answer questions about insurance, billing and appointments.

Does this mean that our patients "get what they pay for?" Absolutely not. They get much more than they pay for. They get the kind of health care that every person deserves. A patient at the Fair Haven Health Center has their own primary care provider; they are tracked for follow up visits, they receive appointments promptly, they have telephone access 24 hours a day to medical advice; they are cared for during hospital stays.

In order to provide this level of care we must look continually to grants and special programs, private and government, to fill the gap. This is also part of the work we do at the Center. We search for the dollars to pay for the programs that our patients need, but may not be able to afford.

Among our patients, there is a small percentage of people who do have health insurance, and could choose a private physician or complete health plan. Instead, they opt to come to the Center because even for these few patients, they get more than they pay for. They receive the satisfaction of directing their health dollars to our inner city Center, and even more importantly, they receive the best of health care.

1988 Donors to the Fair Haven Health Center

The dollars that keep the Fair Haven Health Center operating come not just from government programs and foundations, but from people who care about the Center and the work we do. The dollars come also from civic organizations and businesses and friends of patients and staff.

In 1988, our capital campaign began, and will continue through 1989. In addition to providing the additional space we need, the campaign has given us the opportunity to introduce The Center's work to more people through media releases and individual tours of our facilities.

Contributions to the Center increased in 1988, helping us keep pace with our ever increasing demands we face to provide health care.

We thank all our contributors for this past year:

1988 Donors to the Fair Haven Health Clinic

ANONYMOUS
JEAN AGNOFOLO
MARY ARNSTEIN
ELEANOR BATTIN
CAROL BATTIN AND SAM MAYER
ESTHER BENEER
STEVE BITTNER, MD
MARGARET AND ROLAND BOGUS
JANET BRODIE AND DON WUNDERLEE
SARAH BUBE
ELIZABETH CELLOTTO
TERRY CLARK AND LORNA FERGUSON
DIANE CORMIER
DR. AND MRS. ROBERT CREDE
DAVE CURRAN
JANELLE AND JOHN DUAN
SHERRI AND JOHN ELLIS
MISS ROSELLE ERBY
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DICK GLENDON, MD
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ESTHER HARDENBERGH
THERON, BEV HODGSON AND JOHN LEVENTHAL, MD
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CATHLEEN HOWE
MARY ALICE AND DAVID JOHNSON
ROBERT AND TRICIA KILPATRICK
BARBARA B. LEVIN
ELIZABETH LOWRY, MD
HENRY MACKENDANTZ, MD
CHARLES AND JOANNE MALICK
CARLA MARTELL, MD
GEORGE MCWILENEY, JR
JENNIFER MEIGS, MD
DR. MILLAR AND EMMA SHELTON
ERIC AND GWEN MOOD
OLGA NICHOLAS, MD

MOIRA NICHOLS
ELISE AND DAVID PAPKE
CHRISTINE PATTEE
NORMAN AND GABRIELE PASHETA
BRIAN RIGNEY MD
JOHN RINGWALD
DR. RONALD AND JEAN ROZETT
ISABEL SCHMITZ
MIRIAM SEIDEL AND DAVID BEAUSOLEIL
MARYLOU SHELESKY AND STEPHEN PEARSON MD
GEORGE SILVER MD
AL AND RUTH SIMS
C. THOMAS AND MARTHA SMITH
JOHN STEUER
RAYMOND TANG
DEBORAH TOWNSHEND
MARIA TUPPER
MARION TYLER

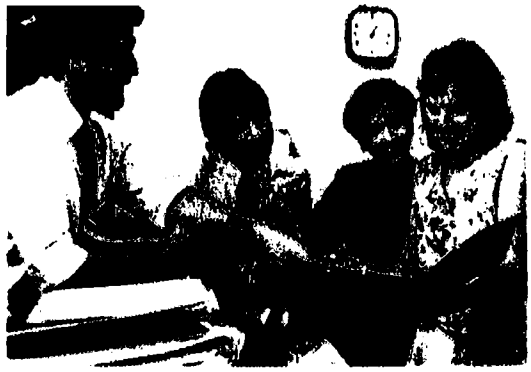
CLUBS AND BUSINESSES
JONES TREE FARM, TERRY AND JEAN JONES
STATE WIDE CLEANING, WOODROW WILSON
BELLA VISTA PROTESTANT FELLOWSHIP
339 CLUB, BELLA VISTA

CELEBRATIONS
IN HONOR OF FLORA ARDITO
CAROL AMATO
IN HONOR OF DR. ANDREW AND ELLEN WORCESTER
STAFF OF THE NEW HAVEN MEDICAL GROUP
IN HONOR OF FR. FATHER JOSEPH GUTTMAN
GILDA OUTERMONT
IN THANKS TO DR. JOSE ASIS ON THE BIRTH
OF THEIR DAUGHTER
EDWARD AND LORRAINE MAURO
IN HONOR OF THE MIDWIVES
AIDA COLON

UNITED WAY DESIGNATIONS
WILLIAM GREDE, MD
DON INGALLS
THOMAS C. JACKSON
JOSEPH CAMPIELLO

IN MEMORY OF
FLORENCE KEEVERS
WR. KEEVERS, FRIENDS, AND FAMILY
MALICK AND KRY/NEL FAMILIES
CHARLES AND JOANNE MALICK
MARIE BARRETT
ANDRADE FAMILY
LINCOLN H. CLARK
KATRINA CLARK
TERRY CLARK AND LORNA FERGUSON
COFFEY MAGENHEIMER FAMILY
FAIR HAVEN CLINIC STAFF AND BOARD
LOUIS PARLEY AND SYLVIA LAVELLES
ESTHER HARDENBERGH
BAYUK, GELLES, MARGOLIES, ROSENBLATT FAMILIES
MARY AND CHARLES DEIBER
ROBERT AND ANN DAHL

Our Staff



With new exam rooms on the way, and the need for clinicians growing more urgent, we went ahead with hiring two new physicians and two nurse practitioners during 1988. Working in close quarters, sharing telephone lines, and revolving through our current exams rooms, our staff displayed remarkable forbearance.

Even in the tumult of growth and expansion, we continue to set aside Friday morning, each week, for staff meetings, team meetings, quality assurance and in-service training. This time for professional growth and communication is an essential element in our approach to health care.

More than anything else, our staff works as a team. From making an appointment through to clinical procedures we coordinate the health care our patients receive. Pediatric staff (l to r), David Appel, MD, Semion Dalbasty, MD, Miriam Ford, FNP and Maria Mauldon, FNP confer on a patient's file.

ADMINISTRATION AND FINANCE

KATRINA CLARK, MPH
Director
BONNIE BAYUK
Assistant Director
LIZ GERSTEN
Financial Administrator
CHARLA NICH
Financial Administrative Assistant
MARIE WILLIAMS
Office Manager & Family Planning Appts. Coordinator

BELLA VISTA

VERA CAPPIELLO
Elderly Services Coordinator
DEVITA KNIGHT
Medical Administrative Assistant
CAROL BREDA, MSW
Social Worker
LINDA SCHUSTER, RN
Nurse

CLINICAL SUPPORT

ANNE BELL ALLEN
Clinical Assistant
GRISELLE CARCAMO
Laboratory Assistant

MARY DESTEFANO
Central Supply Coordinator/Italian Neighborhood Worker
ANNETTE FARINA
Triage Coordinator
LILLIAN MARQUEZ
Healthy Start Coordinator
MARIA MELENDEZ
Well Baby and Outreach Coordinator
CANDI MENDES JENNETTE
Patient Care Coordinator
MILY RIVERA
Appointments Receptionist
MICHELLE ROSE
Clinical and Lab Assistant

BILLING & TELEPHONE SUPPORT

FABIANA NIETO
Billing Telephone Receptionist
PRISCILLA RIVERA
Billing Coordinator
NYDIA ROMERO
Telephone Receptionist
CAROLE RUGGIERIO
Telephone Receptionist
NANCY TORRES
Billing Assistant
MARI VARELA
Medical Records - Receptionist

CLINICIANS

SEMEON TSALBINS, MD
Medical Director/Pediatrician
ELIZABETH MAGENHEIMER, MSN, CNM, FNP
Director of Nursing/Nurse Practitioner, Midwife

DAVID APPEL, MD
Pediatrician
MARGARET BECKER, MSN, FNP
Family Nurse Practitioner
WILLIAM CREDE, MD
Internist
MIRIAM FORD, MSN, FNP
Family Nurse Practitioner
SUSAN FRIES, MSN, FNP
Family Nurse Practitioner
MARY JANE GALVIN, MSN, FNP
Family Nurse Practitioner
SARA GOTTLIEB, MSN, CNM
Midwife
MELISSA LONERGAN, MSN, CNM
Midwife
RUTH MAGRAW, MD
Pediatrician
MARIA MAULDON, MSN, FNP
Family Nurse Practitioner
KATHLEEN MITCHEOM, MSN, CNM
Midwife
LUZ VASQUEZ, MD
Internist
ELEANOR WEINSTEIN, MD
Internist
ELLEN WORMSER, MSN, CNM
Midwife

THE BODY SHOP

BONNIE BAYUK
Coordinator
ADELA RIVERA
Receptionist
MEG BLOOM, MSW
Social Worker, Body & Soul Project
LAURI WINTER, MSN
Coordinator, Body & Soul Project

EDUCATION AND SOCIAL SERVICES

SARAH FORMAN, RN
VIDA Coordinator and Counselor
JUANA POWER
VIDA Outreach Worker
ANNE SOMSEL, RN, MS
Perinatal Program Coordinator, Hypertension Project Coordinator
ELIZABETH MANN
Social Services Case Manager
MARITZA PADILLA
Health Educator for Perinatal and Hypertension Programs

WIC

LIZ GERSTEN
WIC Coordinator
MICHELLE KNIGHT
Nutritionist
DELIA VEGA
WIC Appointments Coordinator

OBSTETRICAL AND GYNECOLOGICAL CONSULTANTS

JOSE AGIS, MD
MURIEL BLOOM-ORIHANE, MD

DERMATOLOGY CONSULTANT

KEVIN DEUTE, MD

Our Volunteers and Part-Time Staff

In 1988, as in past years, volunteers who donate their time have allowed The Center to broaden its programs. At our Bella Vista Satellite, volunteers serve as companions to our elderly patients, run exercise programs, and staff the office. Our Body & Soul project at Wilbur Cross High School benefitted from student volunteer tutors from Yale University. At the Center itself, Pediatric Residents from Yale again volunteered their time by staffing our Tuesday night clinic – a practice begun sixteen years ago.

The center was organized and run by volunteers in its first years, and we have come to rely on the generosity of the people in the community who continue to support us with their time.

PART-TIME STAFF, VOLUNTEERS AND STUDENTS

KARLA BERNSTEIN, RN (Western Connecticut)
MARY BETH DONICA, MD
LAURENCE DEVALENCIA (Yale College)
SUSAN DURAND
NANCY HAZEL, CNM
MARY ALICE JOHNSON, CNM
ANDREW MEYERS
KATHY MAUER, MD
KRISTIN MITCHELL (Yale College)
TONY NICH
ANGEL REYES
POLLY ROSEN (Mammography Van)
ROSALY VEGA (Wilbur Cross Student)
ANDREW WORMSER, MD
LAURA WRIGHT

Carpenter and Maintenance

WILLIAM PLANZ
WANDA MUCHA

YALE SCHOOL OF NURSING CLINICAL PLACEMENTS
Students

LOUEVEA MALBE, RN
SUSAN MORNINGSTAR, RN
MAUREEN WATT, RN

MEDICAL VOLUNTEERS AND CONSULTANTS

Ear, Nose and Throat
JAMES DOWALIBY, MD

Optometry
TIRSA QUINONES

BELLA VISTA
RECEPTION AND CLERICAL VOLUNTEERS
FLORA ARDITO
MILDRED BRASS
CHARLES DEWITT
PAULINE GREEN
HELEN IVINS
JEAN LATIMER

KAY MAGNUSON
LOIS MALLINSON

LOAN CLOSET
JEAN GOLDSTEIN
ANN SOLIMINI
MARY WELDON

SENIOR COMPANIONS
JULIA FIMIANI
JEAN LATIMER
BERNICE LYONS
EILEEN MAURIZI
HELEN PENDER
ORLEANE SANDIFORD
HELEN SEIPOLD
KAY WATROUS
MARY WITYCOMBE

EXERCISE GROUP LEADER
LILLIAN SULLIVAN

YALE COLLEGE STUDENT VOLUNTEERS

BODY & SOUL TUTORS
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FABIENNE CHARLES
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TERESA JONES
GWEN JOYNER
JOHN KEMP
DAPHNE LAMOTHE
PAM LIASE
TONYA LINDSEY
RAMIE LOZANO
BRIAN MCCASKILL
JILL MUNDY
MELISSA NICHOLSON
CHRISTIAN PITTER
DAVID ROBBINS
YASIN SHABAZZ
MICHAEL WARREN
ANITA WELLS
LESLIE WIMS

PEDIATRICIANS
VITA GOEL, MD (Coordinator)
BRAD JUBELIER, MD (Coordinator)
JANET ASPRELLI, MD
NANCY BRAVERMAN, MD
BARBARA GARDNER, MD
MARGARET IKEDA, MD
SUE LIEB, MD
YUK LAW, MD
PAUL MARTIN, MD
ANNE MARIE MELCHREIT, MD
CATHY PEW, MD
ELLEN STECKER, MD
ALISON WONDRISKA, MD

Our Board of Directors

The Board of Directors of the Lois Haven Health Center represents members of our community, patients, health care providers and staff. They meet in addition to their monthly meetings to set policy, approve budgets and [illegible] staff on [illegible] members of the Board were on [illegible] with Quality Assurance, Client Affairs, Fund Raising, Personnel and Finances.

In 1988 the Board concentrated on the [illegible] of the capital campaign for the renovation and [illegible]

Making the dream happen - buying the adjacent building, planning for renovations and organizing a capital campaign required involvement of our Board of Directors. Board President Amy Goldfarb and Capital Campaign Chairman, Donald Ingalls took a walking tour of the building during the first phase of construction.

OFFICERS:

AMY GOLDFARB
President
ISABEL SCHMITZ
Vice President
DONALD INGALLS
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POLLY MOORER
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Client Representative
FRANK PALMIERI
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ALAN WRIGHT

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These figures represent the Operating Budget of the Fair Haven Health Center for fiscal years 1988 and 1989. A certified audit report is available upon request, prepared by the accounting firm of Konowitz, Kahn, Rashba & Leibowitz, PC.

STATISTICS

During 1988, the Clinic served over 8,000 patients in over 27,000 visits, and also served 920 WIC registrants.

1988 Patient Visits

Paying the Bill

Expenses

Revenues & Expenses

REVENUES GRANTS	87-88	88-89
City of New Haven – Community Development	32,505	29,512
City of New Haven – Bella Vista	20,000	20,000
City/State Pregnancy Prevention and Youth	6,000	11,300
State of Conn. – Dept on Aging – Bella Vista	30,600	32,400
State of Conn. – Maternal and Child Health	110,100	117,800
State of Conn. – Family Planning	34,875	38,000
State of Conn. – School Based Clinic	35,000	31,207
State of Conn. – Community Health Centers	12,500	41,000
State of Conn. – Prevention–Blood Pressure	19,000	12,000
Federal/State – WIC (USDA)	72,796	75,500
Federal – Urban Health 330 Grant (DHHS)	260,000	368,809
Federal – Family Planning with PPC	65,000	40,000
Federal – DHHS Body & Soul Demonstration	64,505	67,000
Private – Robert Wood Johnson Foundation	25,000	30,000
Private – New Haven Foundation (Prenatal)	55,000	40,000
US Conference of Mayors – AIDS	0	23,330
Hispanic Male Outreach	0	17,400
	$842,881	$995,258
PATIENT GENERATED		
Title XIX (Medicaid)	238,000	305,000
Title XX (Family Planning)	23,000	25,000
Medicare	60,000	60,000
Private Insurance	40,000	65,000
City Welfare	13,000	10,000
Patient Fees Sliding Fee Scale	50,000	50,000
	424,000	515,000
OTHER		
Contributions/Misc.	11,000	13,500
TOTAL:	**$1,277,881**	**$1,523,758**

EXPENSES		
Personnel & Fringe	1,036,140	1,246,990
Heat, Light, Building Costs, etc.	37,500	33,040
Office Costs (Telephone, supplies, printing, postage)	44,500	44,150
Education Materials and Supplies	4,500	4,750
Patient Care and Medical and Lab Supplies	55,900	62,700
Transportation	3,000	4,000
Insurance (Including Malpractice)	70,000	100,000
Bella Vista Rent	2,365	2,365
Other (Legal, Accounting, Professional Training)	18,000	19,800
Equipment Repairs and Service	10,000	9,000
Mortgage – 372 Grand Avenue	0	9,300
TOTAL:	**$1,281,005**	**$1,536,095**

The band-aid went on, the work began, and we set our sights for 1989. Board Member Donald Ingalls and Director Katrina Clark kicked off our campaign with a press conference on the steps of 372 Grand Avenue.

Fair Haven
Community
Health Center

374 Grand Avenue
New Haven
Connecticut 06513

Mr. MORRISON. And now I would like to call the first panel of witnesses—Lorraine V. Klerman, Professor of Public Health at the Department of Epidemiology and Public Health for the School of Medicine, Yale University; Cornell Scott who is not yet with us but is the President of the Connecticut Primary Care Association and Director of the Hill Health Center here in New Haven; and Kenneth E. Thorpe, Ph.D., Director of the Program on Health Care Financing and Insurance, the Department of Health Policy and Management, School of Public Health, Harvard University, Boston, Massachusetts.

We thank you for being with us today. Your written testimony that has been submitted will be made a part of the record in full. We would appreciate your summarizing your testimony and focusing on those things that you want to emphasize most for the benefit of the panel and those who will be reading the record.

Thank you very much. And, Dr. Klerman, if we could start with you.

STATEMENT OF LORRAINE V. KLERMAN, DR. P.H., PROFESSOR OF PUBLIC HEALTH, DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH, SCHOOL OF MEDICINE, YALE UNIVERSITY, NEW HAVEN, CT

Dr. KLERMAN. My name is Lorraine Klerman, and I am a Professor of Public Health at Yale. My area of expertise is the health of children and of women in their reproductive years.

I wish to begin by stating how honored I am to be asked to testify before Representatives of the Committee that has done so much to inform Congress and the American people about the problems facing children, youth, and families today. This Committee's hearings and its publications have made us all aware of how our society is failing its children, not only in the health arena, but also in regard to income, housing, education, and social support. And we in New Haven, of course, are particularly proud of the contributions of our Representative, Mr. Morrison.

Today the Committee is addressing the issue of access to health care. And I have been asked to provide a public health perspective, including an overview of the status of children's health. Fortunately, the health of most children in the United States is quite good. Most American children are not handicapped nor malnourished, nor do they suffer excessively from illnesses. Why then are we all convinced that there is a problem with access to medical care?

We are convinced because there are subgroups of American children whose health is poor. These include the homeless, those who live in inner city ghettos or isolated rural areas, children in foster care, children in migrant families, children in Native American families, and the list could be continued. Clearly, these families have at least one thing in common—their incomes fall below or near the federal poverty level.

These poor children disproportionately suffer from a variety of health problems. They are born too soon or too small. They are more likely to die in the first year of life from causes associated with low birth weight and prematurity or from SIDS. In subsequent years, they are more likely to die or suffer from AIDS, child

abuse, injuries, infectious disease, chronic medical conditions, anemia, lead poisoning, and vision and hearing difficulties. They are more likely to be hospitalized. Poverty is definitely not good for the health of children.

But why are poor children less healthy than more affluent ones? Certainly problems in paying for essential medical care is one reason, but it is not the only one. My public health perspective makes it difficult for me to believe that even the most inclusive and most expensive insurance program would, by itself, have a major impact on the health status of children.

At least three approaches are needed to improve significantly the health status of poor and near poor children:

1. Improve the basic living conditions of their families;
2. Remove the financial impediments to medical care; and
3. Reduce the other barriers to access, particularly by expanding the capacity of the medical care system to provide the disadvantaged with the full range of services that they need.

Poor children are less healthy than more well to do children only partially because they receive less medical care in relation to their health needs. They are also less healthy because their housing is inferior, their nutrition is inadequate, and their parents know less about what to do to promote health and prevent disease. Even when their parents have this knowledge, they may not have the time nor the money to take the necessary actions.

Thus, if Congress or the state legislatures really want to improve children's health, they must be willing to provide funds for housing; not only to house the homeless, but also to upgrade housing which now exposes children to lead paint poisoning, rodents, inadequate heating or plumbing, unnecessary injuries, and worst of all, violence. Legislators must also consider the expansion of WIC to all low income eligibles, and increasing the availability of school breakfasts and lunches. In many areas, raising the level of AFDC benefits would also improve children's health by enabling parents to buy the things their children need for their physical and emotional development.

Programs that keep adolescents in school until at least high school graduation can improve not only the health of the adolescents through health education and health services, but also the health of their future children by reducing the chance of their growing up in poverty, as well as increasing their parents' knowledge of child health and development.

And since injuries are the number one cause of death among children over age one and of adolescents, funds spent in this area will affect health status. In addition, any program that reduces the availability of illegal drugs will have a powerful impact on children's health by reducing the number of infants with health problems, including AIDS, caused by their parents' addiction and by reducing family and street violence.

The second essential approach to improving children's health is through removing the financial impediments to the receipt of medical care. There can be no doubt that insufficient funds to pay physicians or hospitals prevent many women and children from obtaining the medical care that they need. This country should be able to remove this obstacle relatively easily because the care that chil-

dren need is so inexpensive. Even when the care that sexually active and pregnant women need is included, costs are still very low.

This country is reasonably very concerned about the ever increasing costs of medical care, but children and women in their reproductive years contribute very little to those costs, unless they do not receive preventive care. We need not worry that making necessary medical care available to all children and pregnant women will make medical costs rise appreciably. Some costs might even drop such as those for infants in Neonatal Intensive Care Units.

And, finally, even a well designed system of financing will not make health care available to all the children and women who would benefit from such care. This country's medical care system cannot presently provide primary health care to all children and pregnant women. An improved financing system would probably increase demand more than it would increase the supply of providers.

Thus, in addition to a financing system, this country needs to expand the number of providers willing to serve disadvantaged populations, and particularly providers able to offer the expanded service package that many disadvantaged populations require. You learned about that expanded package at the Fair Haven Health Center.

Any insurance system based on the current Medicaid model will have problems because providers are not reimbursed at the market level, and thus will either not accept Medicaid patients or restrict the number of patients they accept. But even improved fee schedules will not solve all the access problems. Some providers will still be reluctant to treat the poor because they believe that they are more likely to sue. This is particularly a problem in obstetrics. Nor will an insurance program provide sufficient incentives to bring private physicians to areas where they prefer not to practice, such as inner city ghettos and isolated rural areas.

In addition, we must be concerned with the kind, quality, and appropriateness of care. Medicaid mills do not provide adequate care. And we must be certain that such facilities are not encouraged by a financing program.

Many children and pregnant woman need a broader array of services than is usually available through insurance programs. These include home visiting, counseling, addiction cessation programs, food supplementation, and other services not usually provided in office-based practices.

In order to offer the services needed in the places where they are most conveniently sought, a health insurance program would need to be supplemented by funds for community and migrant health centers, for clinics operated by health departments, schools, and family planning agencies, for National Health Service Corps personnel, and for similar capacity building initiatives. These programs provide care in areas where office based physicians and dentists are reluctant to serve, and they offer a wider range of services.

In summary, a health insurance program that would cover family planning, pregnancy, labor and delivery, and medical care for infants, children, and adolescents is certainly essential to the

health of women and children in the United States. It will not be enough, however, if our goals are to improve health status. In order to improve the health of the least healthy, it is essential to improve living conditions that have a major impact on health, that is, to raise family incomes, improve housing, provide sufficient food, and ensure adequate education.

Moreover, even within the health domain, a universal or targeted insurance program will not be effective by itself. Community-based health campaigns to reduce injuries, violence, and the use of addicting substances must also be part of a health promotion strategy. Nor will insurance alone even guarantee access to needed care. Funds will be required to increase the capacity of the medical care system, particularly, to serve the disadvantaged, and to provide the full range of services essential to the health of these populations.

I wish to thank you for this opportunity to share my understanding of children's health care needs with the Committee, and through you with the Congress and the American people. My written statement expands on many of these ideas, and I hope you will include it in the report. And, of course, I am available to answer your questions.

[Prepared statement of Lorraine Klerman follows:]

PREPARED STATEMENT OF LORRAINE V. KLERMAN, PROFESSOR OF PUBLIC HEALTH, DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH, SCHOOL OF MEDICINE, YALE UNIVERSITY, NEW HAVEN, CT

Prepared for Connecticut Field Hearing of the Select Committee on Children, Youth, and Families, United States House of Representatives, held on Monday, December 11th, 1989, in New Haven, Connecticut.

A CHILD HEALTH PERSPECTIVE
ON
The Changing Face of Health Care
The Movement Toward Universal Access

My name is Lorraine Klerman and I am a Professor of Public Health at Yale. My area of expertise is the health of children and of women in their reproductive years.

I wish to begin by stating how honored I am to be asked to testify before the Committee that has done so much to inform Congress and the American people about the problems facing children, youth, and families today. This Committee's hearings and publications have made us all more aware of how our society is failing its children - not only in the health arena, but also in regard to income, housing, education, and social support. We in New Haven applaud your efforts and, of course, are particularly proud of the contributions of our representative, Bruce Morrison.

Today the Committee is addressing the issue of access to health care and I have been asked to provide a public health

perspective, including an overview of the status of children's health. Fortunately, the health of most children in the United States is quite good. Most American children are not handicapped nor malnourished, nor do they suffer excessively from illnesses. Why then are we all convinced that there is a problem with access to medical care?

Poverty and Child Health Status

We are convinced because there are subgroups of American children whose health is poor. These include the homeless; those who live in inner city ghettos or isolated rural areas; children in foster care; children in migrant families; children in Native American families...and the list could be continued. Clearly, these families have at least one thing in common: they are poor by most standards. Their incomes are below or near the federal poverty level.

These poor children disproportionately suffer from a variety of health problems. They are born too soon or too small. They are more likely to die in the first year of life from causes associated with low birth weight and prematurity, or from SIDS (the Sudden Infant Death Syndrome). In subsequent years they are more likely to die or suffer from AIDS, child abuse, injuries, infectious disease, chronic medical conditions, anemia, lead poisoning, and vision and hearing difficulties. They are also more likely to be hospitalized. Poverty is definitely not good for the health of children! (The effect of poverty on children is documented in a monograph I have prepared for the

National Center for Children in Poverty. Copies can be made available to the Committee.)

But why are poor children less healthy than more affluent ones? Certainly problems in paying for essential medical care is one reason; but it is not the only one. My public health perspective makes it difficult for me to believe that even the most inclusive, and expensive, insurance program would by itself have a major impact on the health status of children. Multiple approaches are needed to achieve the goals of reducing unintended pregnancies; premature or low birth weight infants; infant, child, and adolescent mortality rates; preventable diseases; injuries; and, as a consequence, hospitalizations; days lost from school; and, not to be overlooked, pain and suffering. Obviously, these are our health status goals. In addition, we have equity goals. We want the same medical services to be available to our disadvantaged as to our advantaged populations. Unfortunately, in these days of budget crises, we may have to decide between our health status and our equity goals. Given the reasons for excess deaths and disability among the disadvantaged, a health insurance program, even one with universal enrollment, may not be the most efficient method of achieving our health care goals.

Thus, I want to suggest three approaches to improving significantly the health status of poor and near poor children: (1) improve the basic living conditions of their families; (2) remove the financial impediments to medical care; and (3) reduce

the other barriers to access, particularly by expanding the capacity of the medical care system to provide the disadvantaged with the full range of services that they need.

Improve Living Conditions

Legislators and the public should not expect medical care to cure social ills. Medical care can accomplish near miracles in preventing some diseases and in curing others. But traditional office-based medical care can do little to prevent the unintended pregnancies that lead to inadequate prenatal care; the smoking, alcohol consumption, and use of illegal drugs during pregnancy that leads to damaged infants; the injuries and homicides that are major causes of hospitalization and death; and the lead poisoning and anemia that contribute to poor school performance. These health problems require community-based interventions. Most of these interventions are less glamorous then medical care. These include injury prevention programs, food supplementation, and home visiting. Others, unfortunately, are much more controversial than health insurance. They include publicly-subsidized housing, destruction of substandard housing, provision of contraceptives in school-based clinics, and hand gun control.

Poor children are less healthy than more well-to-do children only partially because they receive less medical care in relation to their health needs. They are also less healthy because their housing is inferior; their nutrition is inadequate; and their parents often know less about what to do to promote health and

prevent disease. Even when their parents have this knowledge, they may not have the time or the money to take the necessary actions.

Thus, if Congress or the state legislatures really want to improve children's health, they must be willing to provide funds for housing; not only to house the homeless, but also to upgrade housing which now exposes children to lead paint poisoning, rodents, inadequate heating or plumbing, unnecessary injuries, and violence. Legislators must also consider expanding WIC (the Special Supplemental Food Program for Women, Infants, and Children) to all low income eligibles and increasing the availability of school breakfasts and lunches. In many areas raising the level of AFDC benefits would also improve children's health by enabling parents to buy the things their children need for their physical and emotional development.

Programs that keep adolescents in school until at least high school graduation can not only reduce the rate of adolescent pregnancy and improve the health of the adolescents through health education and health services; but also have the potential to improve the health of their future children through reducing the chance of their growing up in poverty, as well as increasing their parents' knowledge of child health and development.

We are also becoming increasingly certain that community-based programs of injury prevention do work. (This is well documented in an article by Bernard Guyer and his colleagues in the November 1989 issue of the American Journal of Public

Health.) And since injuries are the number one cause of death among children over age one and of adolescents, funds spent in this area will affect health status. In addition, any program that reduces the availability of illegal drugs will have a powerful impact on children's health by reducing the number of infants with health problems, including AIDS, caused by their parents' addiction; and by reducing family and street violence.

Remove Financial Impediments

The second essential approach to improving children's health is through removing the financial impediments to the receipt of medical care. There can be no doubt that insufficient funds to pay physicians or hospitals prevents many women and children from obtaining the medical care they need. (A recent publication of the United Hospital Fund of New York entitled, Poverty and Health in New York City, provides outstanding documentation of the impact of inability to obtain primary health care on health and hospitalization.) This country should be able to remove this obstacle relatively easily because the care that children need is so inexpensive. Even when the care that sexually-active and pregnant women need is included, the costs are still very low.

This country is very concerned about the ever-increasing costs of medical care; but children and women in their reproductive years contribute very little to those costs - unless they do not receive preventive care. We need not worry that making necessary medical care available to all children and pregnant women will make medical costs rise appreciably. Some

costs might even drop, such as those for infants in Neonatal Intensive Care Units.

I will leave the issue of how best to remove financial barriers to the experts you have assembled. However, as an advocate for those most vulnerable members of our society, infants and children, I must urge vigilance. We have learned from Medicaid how expensive it is to provide care to the elderly. We are rapidly learning how expensive it is to provide care to individuals with AIDS. I fear that a comprehensive insurance program will prove more expensive than anticipated. Once again, eligibility and/or benefits will be limited in an attempt to control costs. And, once again, despite their relatively low costs, it will be the preventive medical and social services for children and pregnant women which will cut, not the high technology services for more vocal constituencies. A special access program for children and pregnant women may not be the most politically popular one, but it will undoubtedly be the most cost-effective.

Reduce Other Access Barriers

Finally, even a well-designed system of financing will not make essential health services available to all the children and women who would benefit. This country's medical care system can not presently provide primary health care to all children and pregnant women. An improved financing system would probably increase demand more than it would increase the supply of providers.

Thus, in addition to a financing system, this country needs to expand the number of providers willing to serve disadvantaged populations, and particularly providers able to offer the expanded service package that many disadvantaged populations require. Any insurance system based on the current Medicaid model will have problems because providers are not reimbursed at the market level and, thus, will either not accept Medicaid patients or restrict the number of patient whom they accept. But even improved fee schedules will not solve all the access problems. Some providers will still be reluctant to treat the poor because they believe that they are more likely to sue. This is particularly a problem in obstetrics. (The recent Institute of Medicine report, Medical Professional Liability and the Delivery of Obstetrical Care, documented the loss of maternity care providers and suggested some solutions to that problem.)

Nor will an insurance program provide sufficient incentives to bring private physicians into areas where they prefer not to practice, such as inner city ghettos and isolated rural areas.

In addition, we must be concerned with the content, quality, and appropriateness of care. Medicaid mills do not provide adequate care and we must be certain that similar facilities are not encouraged by a financing program. Many children and pregnant women need a broader array of services than is usually available through insurance programs. These include home visiting, counseling, addiction cessation programs, food

supplementation, and other services not usually provided in office-based practices.

Finally, we must also consider how best to encourage women and children to use the services they need. Programs of outreach and education, reduction in institution-based barriers, and case management are essential. These services are not usually funded through insurance programs, yet can not be ignored if universal access is the goal.

In New Haven we are fortunate in having two community health centers which offer this comprehensive approach to health care - or at least try to offer these services given that increasing numbers of families are seeking care without compensatory increases in funding. The Young Parents Outreach Program (YPOP) at the Hill Health Center is a national model for bringing pregnant adolescents into care and supporting them through their pregnancies. This program had financing support from both the federal and state governments, as well as from the city through the Board of Education's support for the Polly T. McCabe School (an alternative school for pregnant women and young mothers housed in the Hill Health Center complex), and the New Haven Foundation. YPOP, however, was considered a "demonstration project;" and, as is the case with most such projects, its grant funds decreased and then ceased - leaving the Hill Health Center to support one more program with no increase in funds. This is no way to provide universal access!

In order to offer the services needed in the places where they are most conveniently sought, a health insurance program would need to be supplemented by funds for community and migrant health centers, for clinics operated by health departments, schools, and family planning agencies, for National Health Service Corps personnel, and for similar capacity-building initiatives. These programs provide care in areas where office-based physicians and dentists are reluctant to serve; and they offer a wider range of services.

Institutional access issues must also be addresses if children and pregnant women are to receive the care they need. Even in cities like New Haven, where financial barriers have been reduced to a minimum, many remain uncared for. Overcrowded clinics, imposing registration forms, long waits, lack of knowledge of the need for services, insensitive clinicians, drug problem, fear of medical procedures, and other problems contribute to dangerous delays in seeking care. Thus, funding is also needed for community-based program to assist institutions in gaining insights into the barriers they may unintentionally create and to help them solve them. Again, in New Haven we are fortunate in having the Special Commission on Infant Health which has undertaken this assignment, among other. Funded by the New Haven Foundation and with the support of the City of New Haven, the Special Commission has initiated many needed programs, including the Pregnancy Healthline which provides information and appointments for care to sexually active and pregnant women.

What is Still Needed

In summary, a health insurance program that would cover family planning, pregnancy, labor, and delivery, and medical care for infants, children, and adolescents is certainly essential to the health of women and children in the United States. It will not be enough, however, if our goals are to improve health status. In order to improve the health of the least healthy, it is essential to improve living conditions that have a major impact on health, i e. to raise family incomes, improve housing, provide sufficient food, and ensure adequate education.

Moreover, even within the health domain, a universal or targeted insurance program will not be effective by itself. Community-based health campaigns to reduce injuries and violence and the use of addicting substances must also be part of a health promotion strategy.

Nor will insurance alone guarantee access to needed care. Funds will be required to increase the capacity of the medical care system, particularly to serve the disadvantaged and to provide the full range of services essential to the health of these populations.

There are no easy solutions to the problems of health care in this country - and certainly none that do not involve spending more money. In recent years we seem to have been more concerned with whose money is spent than with possible health status benefits. Costs have been shifted between the federal government and the states; between employers and employees; between insurers

and the insured; and among payors. In the long run, however, the bills are paid by the more advantaged either through taxes, raised premiums, or increased product costs.

Eventually legislators and the general public will need to face the realities which other developed countries seem to have grasped. There are basically only a few alternatives. One alternative is to expend more of the gross national product on health care and in that way serve more people and provide more services. Eventually the bill for that alternative must be paid.

If the public is unwilling to pay that bill, the alternatives are to exclude some people from the mainstream of health care - they will not receive the care they need; or to make some services difficult or impossible to obtain by all who could benefit from them. Great Britain, Canada, and other countries have chosen the last alternative. By a variety of mechanisms these countries restrict access to what they consider less essential, "elective," medical services, and thus they restrain costs. But these countries make certain that all, regardless of income, receive essential services. The restricted access to elective services results in long waiting periods for those services. Experts say that Americans would not tolerate such a system. What we have developed instead is a system that attempts to limit costs by restricting the access to health care - even essential services such as prenatal care - of certain populations, the poor and the uninsured; while placing almost no

limits on the medical care that the adequately insured can obtain.

It is possible that some savings can be realized by a more efficient system, particularly one that provides incentives for preventive care. I am afraid, however that we will be deluding the American public if we suggest that manipulations of the system may make it possible to provide universal access to all services without major increases in costs. Basic decisions must be made, even if they are unpopular: increase expenditures for medical care, deny or delay some non-essential services, or continue to make it difficult for some to obtain care.

I wish to thank you for this opportunity to share my understanding of children's health care needs with the Committee, and through you, the Congress and the American people.

Mr. MORRISON. Thank you very much.
Dr. Thorpe.

STATEMENT OF KENNETH E. THORPE, PH.D., DIRECTOR, PROGRAM ON HEALTH CARE FINANCING AND INSURANCE, DEPT. OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF PUBLIC HEALTH, HARVARD UNIV., BOSTON, MA

Dr. THORPE. Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Ken Thorpe. I am currently an associate professor and director of Harvard's program on health care financing and insurance.

In recent months, as evidenced by this hearing, the growing number of private and public sector groups have become increasingly concerned about the performance of our health care delivery system. Among these concerns include continued escalation in health care costs despite at least a decade of public sector interventions, regulations, and most recently, an attempt by the private sector to control their costs.

In addition, Americans are increasingly concerned that, depending on the year the survey is taken, something in the order of 31 to 37 million Americans currently do not have health insurance coverage. Recent studies indicate that a substantial number of the uninsured are children under the age of 17. What we do know from the literature and a number of studies that have looked at this issue is that the lack of health insurance does translate into less access to medical care, and in some instances, poorer health.

These disturbing trends have increased interest in embracing more fundamental changes in the financing of health care in the United States. Many who have studied these health policy issues and their underlying causes are increasingly convinced that incremental changes are not likely to significantly alter the disturbing trends I will shortly highlight. More fundamental changes, including proposals to extend universal health insurance coverage to the uninsured have appeared on the health policy agenda with increased frequency.

I will briefly describe what I view the magnitude of some of the problems are, and conclude with a short list of potential solutions. For ease of presentation, my summary remarks will refer to a series of tables, with which I will not spend a whole lot of time, but they are more for later digestion and for the record.

First, with respect to health care costs, as we all know, we spend more in health care, yet provide less coverage than any country in the world. This year we will spend over $600 billion in health care. We spend more as a percent of GNP on health care than any other country in the world, yet we fail to cover something in the order of 32 million Americans, and provide substandard access to care for that population.

The escalation in health care costs, other than general price inflation, are largely traced to yearly changes in service intensity per patient visit and hospitalization, as well as new technologies. For example, between 1987 and 1988, health care spending went up by approximately $44 billion. Of that total, service intensity, as I just defined as new technologies, accounted for about $17 billion of that increase.

The essential role assumed by the implementation and adoption of new technologies and increasing health care costs is unambiguous. While the new technologies have clearly provided unprecedented health benefits, they also come with a substantial price tag.

Compared to other major industrialized countries, Americans have substantially more access to a wide range of new technologies. As I note in Table 3, if you look at the access to a wide range of technologies in the United States, Canada, and Great Britain, and I think I have Germany there, that there are dramatic differences in the type of technologies, imaging devices and so on that Americans receive vis-a-vis countries that have some sort of universal coverage.

An artifact, which is also a major problem of these increasing costs, are rising private sector health insurance premiums. These premiums have been increasing at rates 2 to 3 percentage points higher than national rates of increase in health care costs.

With respect to coverage, according to the most recent counts, approximately 32 million Americans do not have health insurance. Despite mandatory expansions of Medicaid aimed at low income children and pregnant woman, nearly 9 million children under the age of 18 are also uninsured. An additional 3 million individuals between the age of 18 and 21, some 21 percent of that age cohort, are also without health insurance.

These trends are really traced to three factors.

First, in the face of sustained increases in private health insurance premiums, employers have increased the share of premiums assumed by employees for family health insurance coverage. As a result, fewer dependents are receiving health insurance through employment based plans.

Second, the substantial number of working Americans do not receive health insurance through their place of employment. In 1987, nearly 45 million workers did not receive coverage through their own place of employment. While 30 million of those individuals did find coverage elsewhere, nearly 15 million workers, full time workers, are still uninsured.

In addition, Medicaid currently covers less than half the poor. That is something that has continued to climb since 1975, when Medicaid, on an average, covered about 59 percent of the poor.

With respect to uninsured workers in the work force, about half of them work in small firms. Health insurance costs are substantially higher for small firms for two reasons.

First is that corporations, as you know, are able to deduct the full value of the premiums that they pay, as opposed to self employed individuals, partnerships, and unincorporated firms, who can only deduct one-quarter of their expenses.

Secondly, small firms face substantially higher loading fees than larger firms face, because of the administrative costs of dealing with small firms, as well as the risk of catastrophic expenses. To buy the same set of benefits, small firm versus large firm, could be 20, 30, and in some cases, at least 40 percent difference to buy the same type of coverage.

There are approximately 9½ million dependents of workers, primarily children under the age of 18, who are uninsured. I think the important thing to point out is that this accounts for nearly one-

third of all the uninsured in the country. About one-third of them are dependents of workers.

If you look at what this means with respect to access, clearly the uninsured do get some level of care. They do have some access to care. And you saw some of the types of facilities that they receive care this morning. I think the problem is that that safety net that we traditionally use to provide care, largely uncompensated or through state level granting mechanisms, is really stretched to the limit. Hospitals this year will provide about $11 billion in uncompensated care. And that is an amount as a percentage of costs that continues to grow quite dramatically.

I think reflecting some of those tensions, a recent Robert Wood Johnson survey reports that approximately 1 million Americans reported that they actually tried to receive medical care, but were refused by both physicians and hospitals due to financial reasons. Similarly, an estimated 13.5 million Americans stated they were not able to obtain needed medical care because of inadequate financial resources.

As I alluded to before, the lack of health insurance translates into significantly less access to care. Uninsured children receive approximately one-third fewer physician visits than those with health insurance. This gap appears largest for those with poor or fair health.

Over two-thirds of the uninsured with a serious symptom did not see or contact a physician.

Fully one-fifth of all uninsured pregnant women did not receive prenatal care during their first trimester.

In general, the number of Americans reporting that they did not receive needed medical care is substantially higher than found in other industrialized countries.

Having said that, let me talk about a couple of potential solutions. The litany that we just outlined is fairly discouraging. Throughout the 1970s and 1980s, both the public and private sector have sought solutions to these problems noted above. These are not generally new problems, they are problems that we have had really since 1965 in many ways. What is discouraging is the substantial lack of general effectiveness of these programs to try to control the rate of increasing costs, as well as provide and expand insurance to the uninsured.

There are a number of proposals which have recently been advanced to try to address these issues. These proposals, however, raise a number of issues. Particularly, they raise issues of who should finance these expansions in the face of budget problems that local governments face, state governments face, and our national government faces. In addition, what mechanism would be implemented to ensure that the rate of increase in health care costs would not resume the trends that we have seen of late.

These proposals range from pure public sector approaches, such as Medicaid expansions and buy-ins, to more comprehensive strategies including mandates that employers provide health insurance. And, of course, combinations of these proposals have also been suggested.

In addition, to more effectively manage the growth and health care expenditures, many have suggested that we adopt the Canadi-

an style, single payer system. A version of this proposal was recently advanced in New York state. They have outlined a proposal, which they call UNY CARE, which does adopt many elements of the Canadian system.

These proposals do raise, however, a number of important issues, including the new costs assigned to employers, employees, and governments. I have recently completed a variety of analyses looking at the aggregate and distributional costs of these proposals, and would be happy to address or answer any questions you may have.

[Prepared statement of Kenneth E. Thorpe follows:]

PREPARED STATEMENT OF KENNETH E. THORPE, PH.D., DIRECTOR, PROGRAM ON HEALTH CARE FINANCING AND INSURANCE, DEPT. OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF PUBLIC HEALTH, HARVARD UNIV., BOSTON, MA

Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Kenneth E. Thorpe. Currently I am associate professor and director of the program on health care financing and insurance at the Harvard School of Public Health.

In recent months, a growing number of private and public sector groups have become increasingly concerned about the performance of our health care delivery system. Among these concerns include continued escalation in public and private sector health care payments, and the inability to control these costs despite at least a decade of public sector regulation and more recent private sector interventions. In addition, Americans are increasingly concerned that despite these high costs, over 31 million Americans currently do not have health insurance. Recent studies indicate that a substantial number of the uninsured are children under the age of 17. Lack of insurance translates into less access to medical care and in some instances poorer health.

These disturbing trends have increased interest in embracing fundamental changes in the financing of health care in the United States. Many who have studied these health policy issues and their underlying causes are increasingly convinced that incremental changes are not likely to significantly alter the disturbing trends I will shortly highlight. More fundamental changes, including proposals to extend universal health insurance to the uninsured, have appeared on the health policy agenda with increased frequency. The nature of the problems that private and public policy leaders currently face are substantial. I will briefly describe the magnitude of these problems, and conclude with a short list of potential solutions. For ease of presentation, my summary remarks will refer to a series of tables and figures included at the end of my written remarks.

In summary:

A. Changes in Health Care Costs

- Medical care continues to rise at rates far exceeding the consumer price index. Total health care spending now exceeds $600 billion per year.

- Payments for professional and other services represent the largest components of the yearly changes in health care costs. Between 1976 and 1988, physician and other professional services (combined) increased nearly 175%, over double the rate of increase in the consumer price index.

- Other than general price inflation, continued growth in service intensity and new technologies account for the vast majority of the yearly changes in health care costs. Between 1987 and 1988,

national health care spending increased $43.7 billion, with increased service intensity and new technologies accounting for 40 %, some $17 billion of this change.

- The central role assumed by new technologies in increasing health care costs is unambiguous. While new technologies have allowed unprecedented health benefits, they also come with a substantial price tag. Compared to other major industrialized countries, Americans have substantially more access to a wide range of new technologies (see Table 3).

- One artifact of the sustained increases in health care costs are rising private sector health insurance premiums. Since 1986, private health insurance payments have increased some 2 to 3 percentage points higher than the national average.

- Expenditures for public sector programs have also risen. Since 1987, payments under the Medicaid program have increased even faster than the private sector, most recently jumping 11 %.

B. Changes in Health Insurance Coverage

- According to the most recent counts from the Current Population Survey, some 31.8 million Americans do not have health insurance. Despite the recent mandatory expansions of Medicaid aimed at low-income children and pregnant women, nearly 9 million children under the age of 18 are uninsured (see Table 4). An additional 3 million individuals between the age of 18 and 21, some 21 % of that age cohort, are also without health insurance coverage.

- The rising number of uninsured Americans (through 1987) is traced to two trends. First, in face of sustained increases in private health insurance premiums, employers have increased the share of premiums assumed by employees for family health insurance coverage. As a result, fewer dependents are receiving health insurance through employment based plans. Second, a substantial number of working Americans do not receive health insurance through their place of employment. In 1987, nearly 45 million workers did not receive coverage through their own-place of employment. While 30 million were covered through other means (e.g. they purchase non-group policies or are covered through a spouse's plan), some 14.4 million workers are uninsured.

- Nearly one-half of all uninsured workers are employed by small firms (less than 25 employees). Health insurance costs are substantially higher in small firms relative to larger ones. Two factors account for these higher costs. First, corporations (primarily larger firms) can deduct 100 percent of premium costs for employees as a business expense when calculating their tax liability. Self-employed individuals, partnerships and

unincorporated firms (more likely small firms) may only deduct 25 % of the premium costs. Second, smaller firms face substantially higher loading fees relative to larger firms. The premium differential between small and large employers for the same set of benefits purchased through commercial carriers is between 20 and 30 percent.

- Over 9.4 million dependents, primarily children under the age of 18, of working adults are uninsured. This accounts for 30 % of the total number of uninsured Americans.

- Medicaid fails to provide coverage for approximately one-half of the poor (see Figure 2). Moreover, the percent of the poor covered by Medicaid has decreased over time from a high of 59% in 1975 to approximately 50 % in 1988.

- Due to the flexibility states have in determining AFDC eligibility, the percent of the poor covered under Medicaid varies from a low of 20 percent in Texas to nearly all the poor in California and Hawaii.

C. Access to Care by the Uninsured

- According to a recent Robert Wood Johnson survey, approximately one million Americans reported that they actually attempted to receive medical care, but were refused by physicians or hospitals due to financial reasons. Similarly, an estimated 13.5 million Americans stated that they were not able to obtain needed medical care because of inadequate financial resources.

- Absence of health insurance translates into less access to medical care. Uninsured children receive approximately 34 percent fewer physician visits than those with health insurance. This gap appears largest for those with poor or fair health.

- Uninsured adults received 27 percent fewer physician visits and were hospitalized 19 percent less often than those with health insurance (see Table 7).

- Over two-thirds of the uninsured with a serious symptom did not see or contact a physician.

- Fully one-fifth of all uninsured pregnant women did not receive prenatal care during their first trimester (see Table 8).

- In general, the number of Americans reporting they did not receive needed medical care is substantial higher than found in other industrialized countries (see Figure 3).

D. Potential Solutions

The problems outlined above are substantial and the trends are generally discouraging. Throughout the 1970s and 1980s both the public and private sector have sought solutions to the problems noted above. With few exceptions, these efforts to manage the growth in health care spending, and target resources to those most disadvantages have largely been ineffective. Largely based on these results, a growing frustration in both sectors has evolved, increasing interest in more fundamental reforms of the health care delivery system. Current proposals range from pure public sector approaches (such as Medicaid expansions and buy-ins) to more comprehensive strategies including a mandate that all employers provide health insurance. Combinations of these approaches have also been suggested. In addition, to more effectively manage the growth in health care expenditures, many have suggested the US adopt a Canadian style, single payer financing system. A proposal recently advanced in New York (while retaining private insurers) is an important recent example of this trend. These proposals raise a number of important issues, including the new costs assigned to employers, employees and governments. I have recently completed a series of analyses examining the aggregate and distributional impacts of these proposals and would be happy to address any questions you may have.

Table 1 National Health Expenditures By Source of Funds

(in billions of dollars)

	Total Health Spending		Private Health Insurance		Medicaid	
Year	Total	% Change	Total	% Change	Total	% Change
1983	357.2		98.0		33.9	
1984	388.5	8.8	105.3	7.4	36.4	7.4
1985	419.0	7.9	112.0	6.4	40.3	10.7
1986	455.7	8.8	124.6	11.3	43.6	8.2
1987	500.3	9.8	139.1	11.6	49.4	13.3
1988*	544.0	8.8	153.0	10.0	54.8	11.0

Source: Health Care Financing Administration, Office of the Actuary

* 1988 Figures are Projections

Table 2 Sources of Health Care Cost Growth, 1987-1988

Total Changes in Expenditures =	$43.7	Billion	
Change Traced To:			
. Prices (Inflation)	$22.7	Billion	(52%)
. Population Growth and Aging	$3.9	Billion	(9%)
. Service Intensity (Technology)	$17.0	Billion	(39%)

Source: Author's Calculations Derived from Health Care Financing Administration Office of the Actuary

Table 3 Availability of Selected Medical Technologies in Canada, the United States and Germany (units per million persons)

Technology	Canada	United States	Germany
Open Heart Surgery	1.23	3.26	0.74
Cardiac Catheterization	1.50	5.06	2.64
Organ Transplantation	1.08	1.31	0.46
Radiation Therapy	0.54	3.97	3.13
Magnetic Resonance Imaging	0.46	3.69	0.94

Source: Dale Rublee "Medical Technology in Canada, Germany and the United States" Health Affairs Fall, 1989

Table 4 Uninsured Persons By Age, 1987

Age	Number of Uninsured (millions)	Uninsured As Percentage of Persons in Group
0-6	3.0	13.6
0-17	5.9	14.3
18-21	3.0	20.9
22-44	14.5	16.2
45-64	5.3	11.2
Total	31.8	13.2

Source: Author's Calculations from March 1988 Current Population Survey

Table 5 Relationship of Uninsured to the Workplace, 1987

Workplace Connection	Workers and Dependents Without Insurance Through Job	Number Uninsured	Percent of Total Uninsured
Employed	44.9	14.4	45.3
No Employment Connections	NA	8.0	25.2
Non-working Dependents of Workers	20.8	9.4	29.5
Total	65.7	31.8	100.0

Source: Author's Tabulations From March 1988 Current Population Survey

Table 6

Mean Number of Physician Visits By Insurance Coverage For Children Under 17

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured Children	2.5	6.4%
Insured Children	3.8	6
Gap (percent)	-34%	

Source: Robert Wood Johnson Foundation Survey of Care to the Poor, 1987

Table 7

Mean Number of Physician Visits, Percent Hospitalized, And Perceived Health Status By Insurance Coverage For Persons Under 65

Insurance coverage	Physician Visits	Percent in fair/poor health
Uninsured	3.2	12%
Insured	4.4	9
Gap (percent)	-27%	
	Percent hospitalized	
Uninsured	4.6	12
Insured	5.7	9
Gap (percent)	-19%	

Source: Robert Wood Johnson Foundation Survey of Care to the Poor, 1987

Table 8

Indicators Of Potential Underuse Of Medical Care

Problem	U.S.	Uninsured
Percent with chronic illness without physician visit in a year	17%	20%
Among persons with one or more physician visits in year, percent with serious symptoms who did not see or contact a physician.	41	67
Percent pregnant women without first trimester prenatal care	15	20
Percent of Americans not receiving care for economic reasons	6	20

Source: Robert Wood Johnson Foundation Survey of Care to the Poor, 1987

FIGURE 1

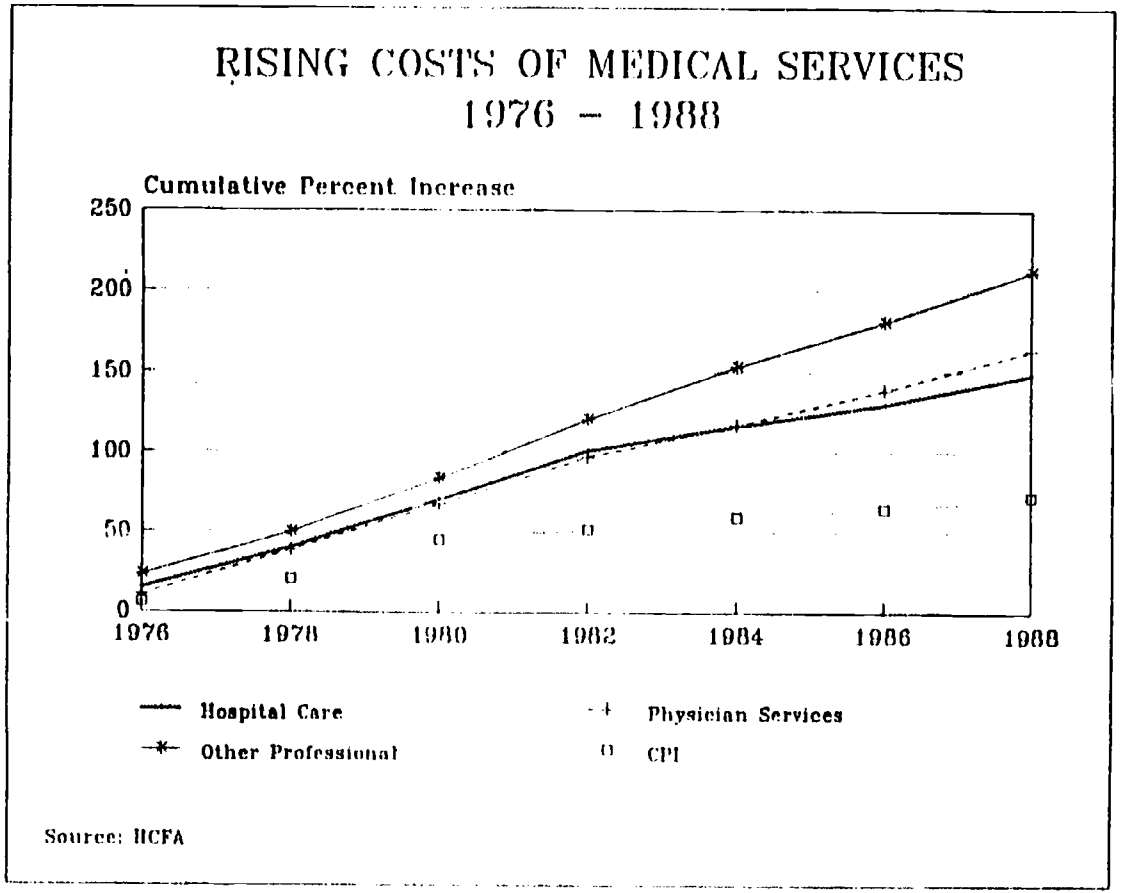

RISING COSTS OF MEDICAL SERVICES
1976 - 1988
Cumulative Percent Increase
250
200
150
100
50
0
1976
1978
1980
1982
1984
1986
1988
Hospital Care
Other Professional
Physician Services
CPI
Source: HCFA

FIGURE 2

Medicaid Recipients as a Percentage of Persons Below 125 Percent of Poverty* 1972 - 1986

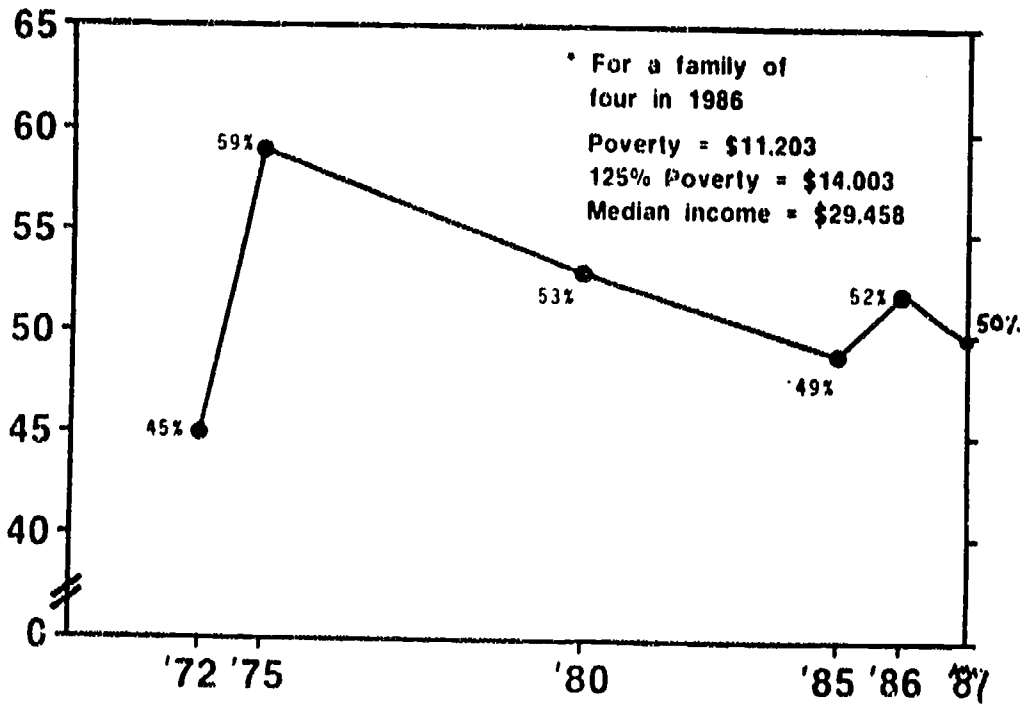
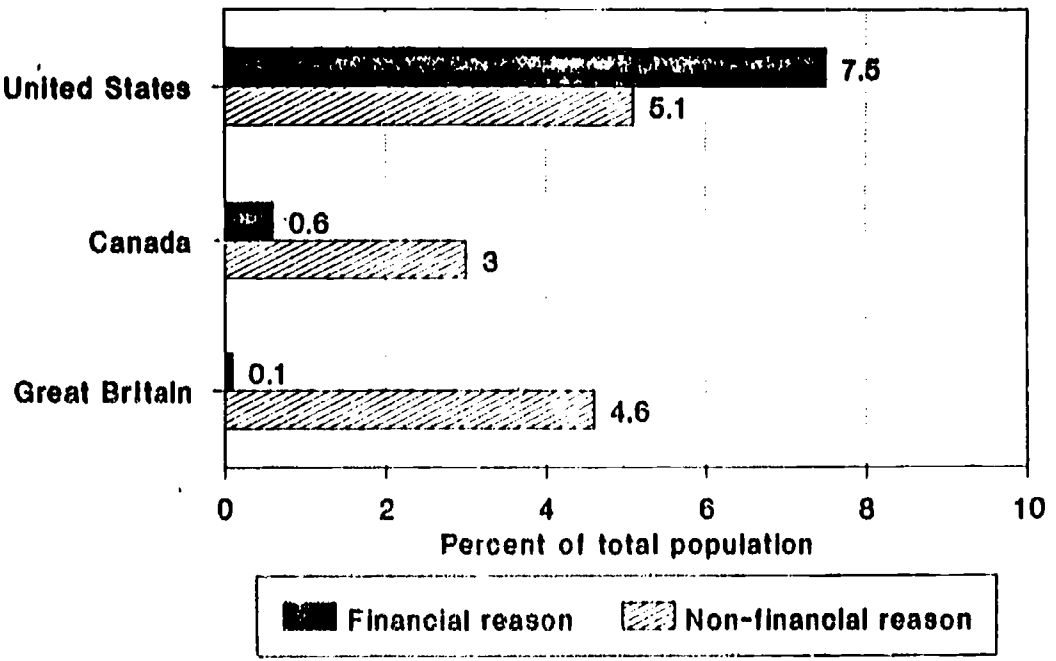


FIGURE 3

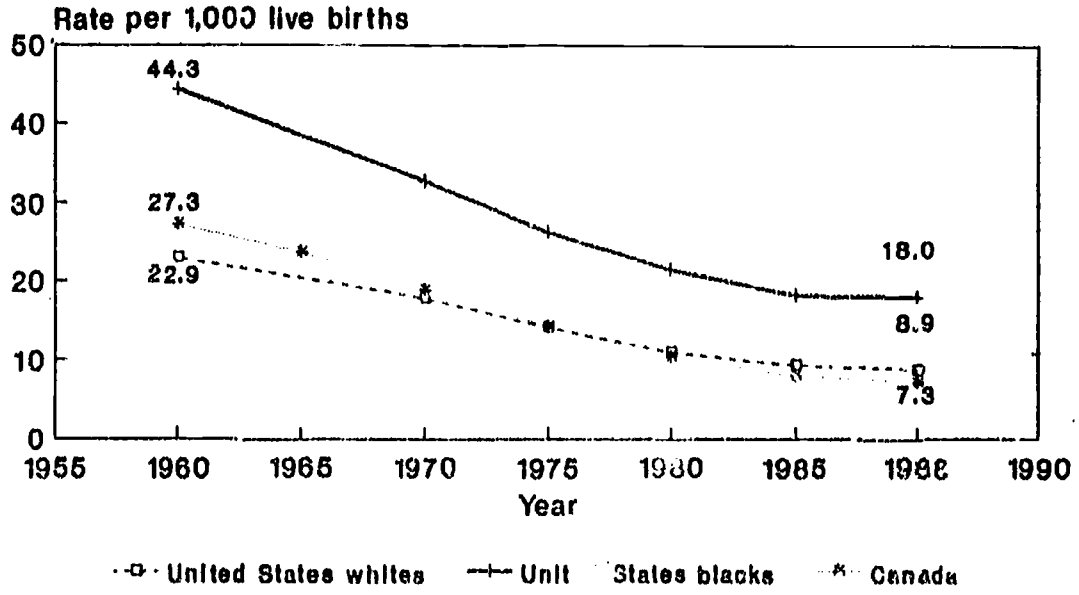
Percent of Americans Who Report They Did Not Receive Needed Medical Care



Source:Health Management Quarterly 1989

FIGURE 4

Infant Mortality Rates
United States and Canada
1960 - 1987



*Data from 1987 are estimated

Special Communication

Covering the Uninsured

Interactions Among Public and Private Sector Strategies

Kenneth E. Thorpe, PhD, Joanna E. Siegel, RN, SM

THE MEDICAID program, designed to provide access to health care for the nation's poor, fails to provide coverage for more than 10.9 million individuals with annual income below the federal poverty level.[1] The gaps in coverage of the poor and the inequities of the current categorical eligibility system have focused interest on Medicaid reform. Recent federal initiatives have incrementally expanded Medicaid eligibility, particularly for poor pregnant women and young children. For proponents of more comprehensive Medicaid reform, however, the cost of expanding the program is an important obstacle. The legislative feasibility of any proposal to extend coverage depends critically on the level of new public sector spending required.

In previous work, we estimated the fiscal impact of a proposal to expand Medicaid eligibility to cover all persons with annual income below the federal poverty level. This proposal, advanced by the Health Policy Agenda for the American People,[2] would require new public spending from $9.1 billion to $14.8 billion.[3] However, public sector spending required to implement Medicaid reform may also be affected by concurrently implemented measures targeting a broader range of the uninsured. Several such measures are currently being contemplated, including both public and private sector approaches to insuring the nation's 37 million uninsured.

This article examines the impact of two recent proposals to cover the uninsured on the cost of a Medicaid expansion. The first, an employer mandate (not specifically recommended by the Health Policy Agenda), would extend private sector coverage to the employed uninsured. The second, a Medicaid "buy-in," would subsidize public sector insurance for the near poor. Implementation of these proposals in isolation or jointly would result in a dramatically different distribution of costs between the public and private sectors. Their impact on the cost of Medicaid reform highlights the importance of the broader debate concerning strategies for covering the uninsured.

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PUBLIC SECTOR COSTS OF SEPARATELY PURSUED MEDICAID EXPANSION

Our earlier analysis, described elsewhere, estimates that expanding Medicaid to the federal poverty line would increase new public spending by between $9.1 billion and $14.8 billion over a baseline $60.9-billion Medicaid budget (1988 dollars).[3] Our most recent estimates of a Medicaid expansion, which include an additional 2.8 million individuals with annual income above the poverty line but suffering from spells of poverty, range from $13.6 to $29.6 billion (1989 dollars). Our discussion focuses on these most recent estimates.

The range in these estimates reflects uncertainty concerning decisions by the currently insured poor to retain private coverage. The lower bound assumes enrollment only by the poor who are currently uninsured, while the higher figure allows for the additional enrollment of all poor who are currently privately insured. Decisions by the near poor to reduce their income to become eligible for Medicaid could further increase the cost of the program by $6.3 billion (Table 1). The incentives affecting these decisions may be summarized as follows:

- Newly eligible individuals who purchase their own private insurance outside the workplace (ie, nongroup policyholders) have a strong incentive to drop their coverage and enroll in the expanded Medicaid program.
- Employers who predominantly insure employees with income below the poverty standard have an incentive to drop their coverage for all employees in favor of the expanded program.
- Uninsured workers with incomes slightly above the federal poverty line have an incentive to work fewer hours, lowering their income enough to become eligible.

Response to these incentives cannot be predicted with certainty. However, the following observations provide a probabilistic ordering of expected costs.

With sufficient outreach efforts, we expect nearly complete participation by the uninsured poor—in fact, the objective of the Medicaid expansion. We estimate this enrollment is 10.9 million using 1987 Current Population Survey data. The Current Population Survey obtains relatively high counts of the annual poverty population as compared with other surveys.[4] However, this figure is based on annual income and therefore undercounts persons living in poverty for shorter periods. In a typical month, another 2.8 million persons would meet the eligibility standard because of short-term spells of poverty. Using current age-specific Medicaid costs for nondisabled recipients,[5] we project that enrolling all eligible uninsured poor would cost the Medicaid program $13.5 billion.

Additional costs would accrue to the expanded program through the enrollment in Medicaid of newly eligible privately insured poor. The incentive to drop private coverage would primarily affect current holders of nongroup policies, usually purchased directly by subscribers. These policies, expensive and more limited than group plans, make state Medicaid packages attractive

alternative.[1] New public costs of enrolling the 3.7 million holders of nongroup coverage with income under the poverty level would add an estimated $4.5 billion to the Medicaid program, raising incremental costs of the expansion to $18.0 billion.

Many poor subscribers to group policies would also benefit from switching to Medicaid coverage. Some employers would likely encourage their low-income employees to drop group coverage and enroll in Medicaid. However, group insurance provisions, which require participation by a substantial proportion of a firm's employees, would prevent a large-scale shift. Only firms employing primarily low-income workers, where the employer would benefit from dropping group health insurance coverage entirely, would be expected to allow their workers to switch. Enrollment in Medicaid by low-income workers would thus depend on the demographics of the firms currently offering group coverage to the employed poor. A $23.2 billion figure, which assumes complete enrollment of the 3.7 million poor with group coverage, is therefore a high estimate of the cost of expanding Medicaid.

The poverty level eligibility standard could, however, influence labor supply decisions of those just above the eligibility threshold, resulting in the additional enrollment of currently nonpoor individuals in Medicaid. Participants in a negative income tax experiment demonstrated that employees will reduce the number of hours worked to become eligible for cash assistance and in-kind transfers.[2] As the annual income guarantees under the negative income tax were more generous than in-kind Medicaid benefits, the negative income tax work reduction of 5 to 7 hours per week is the maximum expected to result from an income eligibility standard for Medicaid. Assuming an average 35-hour workweek, reductions of this magnitude could make eligible an additional 4.5 million persons with current income between 100% and 125% of the poverty line. Enrollment of this group would add $6.3 billion to the cost of Medicaid. Our highest estimate of the cost of expanding Medicaid eligibility is therefore $29.5 billion, which would increase total Medicaid spending by approximately 50%.

To summarize, the range of estimates provided above depends primarily on two factors: (1) decisions by the privately insured poor to retain their coverage and (2) response to any work disincentives by those with income just over the poverty line. Mandated health insurance and Medicaid buy-in proposals would affect both of these areas of uncertainty. The potential impact of these proposals is described below.

PUBLIC SECTOR COSTS—MEDICAID EXPANSION WITH EMPLOYER HEALTH INSURANCE MANDATE

Proposals to mandate health insurance coverage through the workplace are designed to extend coverage to the large proportion of the uninsured (over two thirds) with an attachment to the work force. An example is the recently proposed Kennedy-Waxman Basic Health Benefits for All Americans Act (S.768, HR1845). This bill would, among other provisions, mandate that all firms offer health insurance to full-time workers, extending coverage to 24.6 million uninsured workers and their dependents (Table 2).

The additional cost of this expansion of employer-provided insurance would be financed by the private sector, but would affect the public sector as well. The burden to employers would consist of an estimated $33-billion increase in insurance premium payments.[3] This increased labor cost could result in the loss of an estimated 60,000 to 100,000 jobs, mostly in small businesses in the retail, service, and construction industries.[3,5] Increased health insurance premiums would also reduce either money wages or corporate profits, decreasing federal tax revenues on the order of $5 billion.[3,5]

Even with an employer mandate, however, more than 12 million nonelderly persons would remain uninsured. Nearly half of these would be part-time

Table 1 - Projected Gross Costs of Extending Medicaid Eligibility to 100% of the Federal Poverty Standard*

Current Insurance Status	No. of Persons Newly Eligible, Millions†	Projected Cost to Insure, Billions of 1989 Dollars
Uninsured	13.1	13.5
Non-group insured	3.7	4.5
Group insured	3.7	5.2
Subtotal	20.5	23.2
Uninsured and non-group insured with income 100% to 125% of poverty level‡	4.5	6.3
Total	24.9	29.5

*Source: authors' calculations from March 1987 *Current Population Survey* and 1986 Health Care Financing Administration Form 2082 data file. Does not include reductions in public spending resulting from extending public health insurance. Includes 8% administrative costs.

†Numbers are persons eligible for Medicaid during a typical month.

‡Represents working persons affected by work disincentives.

Table 2 Coverage and Public Costs of an Employer Mandate With Medicaid Expansion to the Federal Poverty Line*

% of Federal Poverty Line	Insurance Status of Newly Mandated Persons Prior to Mandate, Millions of Persons†			Remaining Uninsured Prior to Medicaid Expansion, After Mandate, Millions of Persons	Remaining Uninsured After Expansion and Mandate, Millions of Persons	New Medicaid Program Costs (Uninsured Only), Billions of 1989 Dollars§	New Medicaid Program Costs (Uninsured and Nongroup), Billions of 1989 Dollars¶
	Uninsured	Privately Insured					
		Nongroup‡	Group§				
0-100	5.6	1.2	0.2	5.3	0	9.9	11.5
101-200	7.6	2.1	1.3	3.4	3.4	0	0
>200	11.4	7.0	11.8	3.7	3.7	0	0
Total	24.6	10.3	13.3	12.4	7.1	9.9	11.5

*Source: authors' calculations from *Current Population Survey* March 1987 and 1986 Health Care Financing Administration Form 2082 data file. Costs reported are gross new Medicaid expenditures. These totals do not reflect other changes in public sector spending resulting from the mandate.

†Totals include all those newly mandated under S.768, but exclude 8 million newly mandated individuals previously covered by Medicare, Medicaid, or the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

‡Includes those purchasing coverage outside the workplace.

§Represents employed spouses of currently insured persons covered by their own employer under an employer mandate.

¶Assumes only uninsured below poverty line enroll in expanded Medicaid program after implementation of employer mandate.

#Assumes both uninsured and unemployed and part-time workers purchasing nongroup policies enroll in expanded Medicaid program after implementation of employer mandate.

workers, unemployed persons, or their dependents living in poverty. An extension of Medicaid to the poverty line would supplement the mandated private sector expansion with public sector coverage of this group. Approximately 30 million individuals would be covered by the combined strategy, reducing the number of uninsured to 7.2 million nationwide (Table 3).

Because of the large proportion of the poor who work, the employer mandate would diminish the public sector role of providing insurance for the poor. The mandate would affect both those currently eligible for Medicaid and those newly eligible under an expanded program. Some 3 million employed recipients of Medicaid would receive workplace coverage, reducing the cost of the current Medicaid program by at least $2 billion.[8][9] More than 5.6 million currently employed uninsured workers and their dependents living in poverty would also be covered by the mandate. As a result, new public costs of covering the uninsured poor with an expanded Medicaid program would be reduced to $9.9 billion, only about half the amount required to cover the uninsured poor in the absence of a mandate.

The mandate would also extend group health insurance to more than 1.2 million poor who currently purchase nongroup policies, reducing the number of insured poor potentially switching into an expanded Medicaid program. Switching by the remaining 1.9 million poor with nongroup policies would increase program costs by about $2.1 billion, to $11.5 billion. The upper-bound estimate for covering those under the poverty level thus falls from $29.5 billion to $11.5 billion following an employer mandate.

MEDICAID EXPANSION CONTAINING A BUY-IN PROVISION

An expansion of Medicaid to the poverty line would still leave substantial numbers of near poor individuals uninsured. Recognizing the potential inequities introduced by a strict income threshold, proposals to allow the near poor to buy in to the Medicaid program are designed to extend coverage to this population.

One example of a Medicaid buy-in was proposed in the last Congress by Sen John Chafee (R, RI) (S.1139). This program would allow premium-based participation in Medicaid for persons with an income between 100% and 200% of the federal poverty level. The buy-in premium, a key design component balancing the subscriber contribution against the amount of public subsidy required, would be limited to 3% of adjusted gross family income. This low premium level would eliminate the incentive to become Medicaid eligible by reducing hours of work for all but those earning less than 103% of the poverty line (Table 4). However, the public sector would absorb the bulk of the cost of insuring subscribers.

While enrollment of the near poor in a traditionally welfare-related program is difficult to predict, some 11.1 million uninsured and 5.1 million nongroup policyholders could purchase coverage through this arrangement. Those who currently purchase nongroup coverage would be most likely to buy into Medicaid, dropping their more expensive nongroup coverage to enroll. Some portion of the uninsured would also be likely to participate.

Complete participation by the 16.2 million uninsured near poor and those holding nongroup policies would cost an estimated $22.9 billion (Table 5). The cost to Medicaid would be offset by subscriber premiums of $4.5 billion, reducing the public sector cost of the buy-in to $18.4 billion (Table 6). New public costs would thus include $4.6 billion to subsidize persons who currently purchase nongroup insurance. The remaining amount, $13.8 billion, would subsidize

Table 3 - Characteristics of Remaining Uninsured Less Than 65 Years of Age With Implementation of Employer Mandate and Medicaid Expansion, in Millions*

	Income (% of Federal Poverty Level)			
Age, y	100-200	201-300	>300	Total
0-5	0.4	0.1	0.1	0.6
6-20	1.0	0.4	0.5	2.1
21-44	1.2	0.6	1.0	2.8
45-64	0.8	0.4	0.5	1.7
Total	3.4	1.6	2.2	7.2

*Numbers may not add up to totals because of rounding

Table 4 - Premiums for a Medicaid Buy-In Program

% of Poverty Level	Income of Family of Four in 1987, $	Maximum Family Contribution, $	Amount of Earnings Above Poverty Line, $
100	11650	350	0
103	12000	360	350
105	12233	367	583
110	12815	384	1165
125	14563	437	2913
150	17475	524	5825
175	20388	612	8738
200	23300	699	11650

Table 5 - Estimated Cost of Medicaid Coverage for the Near Poor by Current Insurance Status*

Income Level (% of Federal Poverty Level)	No. of Persons Uninsured, Millions	Projected Cost to Insure, Billions of 1989 Dollars	No. With Nongroup Coverage, Millions	Projected Cost to Insure, Billions of 1989 Dollars	Totals: Persons, Millions	Totals: Cost, Billions of 1989 Dollars
100-125	3.4	4.6	1.1	1.7	4.5	6.3
125-150	2.9	3.9	1.2	1.8	4.1	5.7
150-175	2.4	3.1	1.4	2.0	3.8	5.4
175-200	2.4	3.4	1.4	2.0	3.8	5.5
Total	11.1	15.2	5.1	7.7	16.2	22.9

*Source: Author's calculations from Current Population Survey, March 1988, and Data Health Care Financing Administration Form 2082 data file.

[illegible] for currently uninsured near-poor individuals.

The costs described above do not include offsets to these public costs, however. Because the public sector currently underwrites care for the poor and the near poor through a variety of programs, such offsets could be substantial. The largest would result from reductions in uncompensated hospital care. The uninsured with income below 200% of the poverty line generate an estimated $6.6 billion in uncompensated care costs annually (1989 dollars).[22] State and local governments finance about one third of this expense through tax levy support of public hospitals.[23] Reduction in uncompensated care for the poor and near poor would therefore replace public subsidies of an estimated $2.3 billion with Medicaid payments for buy-in participants. In addition, state and county programs currently provide or finance care for low-income and medically indigent individuals at a cost of approximately $3 billion annually.[24] While no available data describe the proportion used to provide care to the near poor, it is likely that some reduction would occur. New Medicaid program expenditures, 55% federally financed under current matching arrangements, would thus replace spending in diverse local, state, and federal programs currently providing for the medically indigent.

The proposed Medicaid buy-in therefore provides for a significant expansion of insurance coverage financed largely by the public sector and targeting the low-income uninsured. When combined with a Medicaid expansion, complete participation by the 11.2 million near-poor uninsured and nongroup policyholders would reduce the number of uninsured nationally to 15 million.

MEDICAID EXPANSION [illegible] COMBINATION [illegible] BOTH [illegible] BUY-IN PROVISION [illegible] MANDATED EMPLOYER [illegible] COVERAGE

Implementation of an employer mandate followed by a Medicaid expansion and buy-in would combine broad public and private sector approaches to provide coverage for more than 31 million of the 37 million uninsured at all levels of income. The employer mandate would provide primary workplace coverage for 21.6 million previously uninsured employees and dependents. With the prior implementation of the mandate, the Medicaid expansion would cover 5.3 million uninsured persons poor throughout the year, plus an additional 1.3 million temporarily poor during any given month. The buy-in would offer subsidized coverage to an additional 3.4 million previously uninsured near poor.

This combination of strategies would draw on public and private resources, providing coverage both on the basis of employment and on the basis of income. Implementation of the mandate [illegible] markedly reduce the [illegible] the buy-in, in addition [illegible] expanded Medicaid program [illegible] date would cover 6.8 million working poor and their dependents and [illegible] lion employed near poor and their dependents. The public sector would provide coverage for the remaining [illegible] and near poor and their dependents, assuming that [illegible] non-group [illegible] switched to public insurance, as many as 7.2 million poor not covered by the mandate could enroll in Medicaid at a cost of $11.5 billion and as many as [illegible] near-poor persons could [illegible] buy-in at a gross cost of $7.6 billion (Table 7).

The significant extension of private sector insurance accomplished by an employer mandate would thus allot a considerable share of the costs of insuring the uninsured to the private sector. [illegible] poor and near [illegible] cost of subsidizing [illegible] would be covered [illegible] would be reassigned [illegible] tor, along with [illegible] than 7.4 mil [illegible]

[illegible]

[illegible] proposal would have dram[illegible] tions for the private sector [illegible] therefore, is the appropriate assignment of costs between the public and

Table 6.—Additional Persons Newly Eligible for Medicaid and Costs* With a Medicaid Buy-In Above the Federal Poverty Line

Poverty Level Eligibility Standard, %	Newly Eligible Persons, Millions†	Gross Cost to Cover, Billions of 1989 Dollars	Premium Contribution, Billions of 1989 Dollars‡	Public Sector Cost, Billions of 1989 Dollars§
125	4.5	[illegible]3	1.1	5.7
150	4.1	5.[illegible]	[illegible]	[illegible]
175	3.3	[illegible]	[illegible]	[illegible]3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]3
Total	13.2	22.3	[illegible]	[illegible]

*Source: authors' calculations from *Current Population Survey*, March 1987, and 1986 Health Care Financing Administration Form 2082 data file. †Represents total number of uninsured individuals and those with nongroup plan eligible for the buy-in.

‡Premiums contributed by those families newly enrolled in Medicaid.

§Totals do not include reductions in public sector expenditures (eg, public hospital support) [illegible] from the buy-in.

Table 7.—Enrollment and Costs of Medicaid Expansion and Buy-In Program Following the Implementation of an Employer Mandate

	New Enrollees, Millions	Cost, $ Billions
Without employer mandate		
Medicaid [illegible]	[illegible]	[illegible]
Medicaid buy-in	[illegible]	[illegible]
Total	[illegible]	[illegible]
With prior implementation of employer mandate		
Medicaid [illegible]	[illegible]	[illegible]
Medicaid buy-in	[illegible]	[illegible]
Total	13.[illegible]	[illegible]

[illegible] Includes all uninsured and privately insured persons (nongroup and group private coverage) with income below 100% of the federal poverty standard.

[illegible] Includes uninsured and nongroup privately insured persons with income between 100% and [illegible] poverty line. Costs do not include participants' premium contribution.

[illegible] Includes uninsured and nongroup privately insured persons with income below 100% of poverty [illegible] covered by mandated workplace insurance.

[illegible] Includes uninsured and nongroup privately insured persons with income between 100% and 200% of poverty standard not covered by mandated workplace insurance. Costs do not include participants' premium contribution.

Table 2. Impact and Cost of Strategies for Covering the Uninsured

Program	Total No. Affected, Millions	No. of Previously Uninsured Persons Covered, Millions	No. of Uninsured Poor Covered, Millions*	Remaining Uninsured Poor, Millions	Total Remaining Uninsured Nationally, Millions	Estimated Gross Cost, Billions of 1989 Dollars†		Total Cost, Billions of 1989 Dollars
						Public	Private	
Medicaid expansion	20.5	10.9	10.9	9	26.2	23.2	0	23.2
Medicaid expansion	50.1	39.9	10.9	0	7.2	9.5	33	42.5
	48.2	24.6	5.6	5.3		(.20)	33	
	7.7	5.3	5.3	0		11.5	0	
	33.9	22.0	10.9	0	15.1	41.8	4.5	46.3
	12.7	10.9	10.3	0		23.2	0	
	16.2	11.1	0			18.4	4.5	
	51.9	33.4	10.9	0	3.8	17.1	34.6	51.7
	11.9	24.5	5.6	5.3		(.20)	33	
	7.7	5.3	5.3	0		11.5	0	
	6.5	3.1	0			7.6	1.6	

*Adds all persons with annual income less than 133% of poverty line. Cost include additional persons qualifying for Medicaid on the basis of monthly income where applicable.
†Gross costs, not subtracting costs or offsets as noted.
‡Includes tax penalties by the insured poor (both group and nongroup covered) as well as the uninsured poor.
§Assumes enrollment of 70 eligible uninsured near poor, group insured persons not covered by the mandate.
¶Cost of buy-in (gross cost minus premiums).

private sources of providing basic health coverage to the uninsured poor.

The expansion of Medicaid pursued in isolation, a purely public sector approach to providing coverage for the uninsured poor, would likely result in a substantial redistribution of costs from the private to the public sector. While the public sector cost of including the uninsured poor would amount to $13.5 billion, the potential enrollment of persons who currently subscribe to nongroup or group health insurance would shift up to $9.7 billion in additional costs to the program.

A Medicaid buy-in, implemented without stipulations affecting private sector coverage, would extend insurance to the near poor at a substantial additional cost to the public sector. This cost would depend importantly on participation rates and the amount of subsidization provided. In addition, costs of this program would be offset by reductions in the cost of current public programs serving the near poor. The gross costs for coverage of 16.2 million uninsured and non-group-insured near poor, however, would approach $51.4 billion. At least $4.6 billion of this amount would represent a financing obligation shifted from the private to the public sector.

Prior implementation of the employer mandate would significantly reduce costs of both the Medicaid expansion and the buy-in. The mandate would provide coverage for 5.6 million working poor and their dependents, assigning responsibility for almost half the uninsured poor to the private sector. Costs of the expanded Medicaid program would be reduced to as little as $11.5 billion as a result. Near full coverage of 9.7 million of the near poor eligible for a buy-in program would reduce costs of this program to $7.3 billion. However, implementation of the mandate would impose a $33-billion burden on the private sector. This cost to firms and individuals would be accompanied by employment effects and decreased tax revenues. While the employer mandate would accomplish a major reduction in the size of the uninsured population, therefore, its impact on the private sector would be substantial.

The cost of expanding the Medicaid program thus depends critically on a decision concerning the appropriate role of employers in providing coverage for the uninsured. This decision affects 24 million uninsured with ties to the work force, over two thirds of the total uninsured. Within the larger group of uninsured, however, this decision affects a group of employed poor and near poor who would enroll in an expanded Medicaid program in the absence of a mandate. This group could join either the publicly or privately insured, depending on the financing scenario. Because they are low income, they could be included in public insurance programs; because they are employed, however, they should arguably be covered through the workplace. The decision concerning who should provide coverage for these 16 million persons underlies the choice of a strategy for insuring the uninsured poor in this pluralistic system. It determines whether the Medicaid program will become the primary provider of insurance for the poor and possibly the near poor, or whether it will serve as a public safety net within a broader employment-based insurance system.

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Mr. MORRISON. Thank you very much.

Cornell, if you would join us at the witness table.

Cornell Scott, President of the Connecticut Primary Care Association; Director of the Hill Health Center has arrived. We would be happy to receive your written testimony in full as part of the record, and invite you to summarize it and emphasize those things you want us most to hear.

STATEMENT OF CORNELL SCOTT, PRESIDENT, CONNECTICUT PRIMARY CARE ASSOCIATION; DIRECTOR, HILL HEALTH CENTER, NEW HAVEN, CT

Mr. SCOTT. Thank you, Mr. Morrison. As you have indicated, I am Cornell Scott, President of the Connecticut Primary Care Association, and also Director of the Hill Health Center here in New Haven. I am delighted to be here this morning to offer a few comments, and thank you very much for this opportunity.

What I will try to do in the time allotted me is first discuss what we view as the problems from the Primary Care Center's point of view, look at our model and how we think we have been effective in providing services to the uninsured, as well as to children and families. What I will try to do, I know that you have heard the bare statistics, but I hope you will allow me to summarize here very briefly some that are significant for us.

In 1980, we noted that 11.4 percent of children lived in poverty in Connecticut. Out of that number, 34 percent of the children were black, and 42 percent were latinos. Obviously, the poverty sets the environment for the following statistics.

First, is the obvious lack of access to health care, especially from minorities and low income populations. But when we look at the health status, we find a higher infant mortality rate, high HIV infection rates, higher teen pregnancy rates, more untreated hypertension, more chronic diabetes, and other chronic diseases, which reduce life expectancy, and also impair the quality of life.

For the period, for instance, from 1984 to 1986, infant mortality for whites in Connecticut was 8.5 deaths per thousand life births, while for non-whites this number was 17.4. However, this does not tell the full story because if we look at some of the inner city communities, we find that the infant mortality rate is 20 or higher.

And for low birth weight, which is a major health problem associated with lack of access, the number is equally as gloomy. We find that the rate for whites at the same time is 5.5 percent, and for non-whites 12.3 percent. And this is a very sad statistic.

When we look at other indicators of health status, for instance, births to teens in Connecticut, the percentage of births to teens is three times the rates for blacks as for whites. We also note that there has been an increasing rise in syphilis, and this has been felt strongly in the urban communities.

Now, AIDS, obviously, has taken its toll, and I do not have to repeat these statistics for New Haven. But we know that for blacks and Hispanics the impact is severe. They represent 52 percent of the diagnosed cases, while they constitute only 11 percent of the population in the state of Connecticut. And we can break this down by cities as well.

This should be noted with a considerable degree of distress because what we have identified as being prevalent, the illnesses and problems are often preventable, treatable, and controllable with adequate access to care. Thus, the need becomes very obvious.

What is the present state of primary care for low income populations in our state? Primary care for low income populations is, obviously, fragmented, and we might describe it as being underdeveloped.

There is a reluctance on the part of many private providers to serve the Medicaid and uninsured population. There are sometimes local and cultural barriers even when the services are provided. Inadequate transportation is often a barrier for many people. And often those providers who serve the population are overburdened and experience many frustrations, including broken appointments, which, obviously, complicate things not only for the provider of service, but also the beneficiary.

There are roughly 64 census tracks in Connecticut that have been designated either medically underserved, or having a health manpower shortage area. There would likely be more were we to do this analysis today. This situation existed some time ago when the statewide analysis was done.

If we define populations at risk for 1) poorer health status and, 2) lack of access as those persons at incomes below 185 percent of the federal poverty level, there are approximately 592,238 persons, 20 percent of the state's population in this category.

If we look at the major urban centers in this state, we find the following: New Haven, 45 percent; Hartford, 46 percent; Bridgeport, 38 percent; and Waterbury, 30 percent.

If we look briefly at the uninsured in Connecticut from our vantage point, we find that a major segment of the low income population falls into this category. It is estimated that 352,000 people are uninsured in this state based on a 1987 survey. Another 200,000 individuals are on Medicaid and city welfare. This translates into about 11.3 percent of the population. However, approximately 16.5 percent of the black and non-white population are uninsured.

Of the above total, 120,000 individuals are in the age category of 0 to 19 years of age. 34 percent of Connecticut's uninsured; 133,000 are in the age category of 20 to 29 years, 38 percent of Connecticut's uninsured. In summary, these population groups represent about 72 percent of the state's uninsured. And nationally, you have undoubtedly heard the figure, it is estimated that 78 percent of the uninsured are either workers or dependents of workers according to the Employment Benefit Research Institute's 1986 survey.

In the U.S., 53 percent of the children are in poor, single parent families, and uninsured. Forty-three percent of the children were in poor, two parent households, and uninsured. When we look at the impact of this on the status of health care, we, obviously, have to consider access and utilization. And what we find, generally, is that the uninsured have fewer physician visits, higher hospitalization rates than the insured, leaving a real gap in care.

Currently there is an access problem, which translates to the lack of primary care and prevention services. What then is the role of community health centers. This model has been described as

probably the most effective model for large, low income urban populations, as well as rural populations, in providing access to care.

First, the Centers are community based, located in the areas of greatest need, frequently described as medically underserved area. In Connecticut, the centers are located in cities, towns, with 19 percent of the total population, but with 32 percent of the population below 185 percent of poverty.

The Centers serve low income populations. About 80 percent of the populations served in these centers are below poverty level. They have demonstrated a very positive impact on health status, reducing infant mortality, infectious diseases, caring for hypertension, and, obviously, reduced hospitalizations, which are quite costly.

It follows then that Centers are cost effective. In the hospitalization area alone, there has been anywhere from a 30 percent reduction in costs anywhere up to 50 some percent. Centers are family oriented, emphasizing case management, outreach, and "patient pursuit," as we like to call it, finding those people who are in greatest need, and making sure that they get the care that they have not been accustomed to, or not had before.

Centers are comprehensive. It is interesting now to hear the Assistant Surgeon General use the term "one stop shopping". We have called it "comprehensive," which means providing as many services in one place as possible, so that people do not have to go from place to place to get the basic care that they need.

Centers provide a wide range of services. The services range from pediatric services to care for the elderly, substance abuse, nutrition, pre-natal care, teen pregnancy prevention, and more recently, a couple of our centers, a group in New York, and our own Hill Health Center, have received grants from the National Institute of Health for AIDS clinical drug trials, which means that for the first time community based organizations are able to make drug interventions available to a needy population. The centers are accessible, with convenient hours, locations, making sure that there are no language barriers and eliminating financial barriers.

Briefly, who is served? In 1980, there was 66,200 persons with over 215,000 visits to our centers. In terms of the racial ethnic mix, 82 percent of the population was black and Latinos. Women and children, women of childbearing age (15 to 44 years) plus children age 14 or younger, account for 70 percent of the visits. Insurance status—approximately 25 percent of all visits in 1987 were to uninsured individuals. This figure has likely increased by now. However, at two centers it should be noted that over 40 percent of the visits were by uninsured individuals.

In summary, I think that it should be noted that there are towns in Connecticut with more than 20 percent of their populations at incomes below 185 percent of poverty who do not have access to primary care, or do not have community health centers. And this is a great need.

I can go on, but let me stop now and thank you for this opportunity. And I would be happy to answer any questions that you have.

Thank you.

[Prepared statement of Cornell Scott follows:]

Prepared Statement of Cornell Scott, President of the Connecticut Primary Care Association and Executive Director of the Hill Health Center, New Haven, CT

Mr. Chair and Members of the Select Committee on Children, Youth and Families, I am Cornell Scott, President of the Connecticut Primary Care Association and Executive Director of the Hill Health Center here in New Haven. I am pleased to be here today for this hearing of the Committee in New Haven on alternatives to financing health care for families and children in the U.S. On behalf of all the community health centers in Connecticut, we commend you for your efforts to improve access to care for the thousands of children and families in our state and nation.

My comments will be around the issues of access to health care in Connecticut - with a focus on the uninsured. I will also speak briefly on the role that community health centers play in improving access to care for thousands of individuals in our state.

In 1980 11.4 percent of children lived in poverty in Connecticut. However, 34 percent of the children were Black and 42 percent were Latinos. The poverty sets the environment for the following gloomy statistics: first there is the obvious lack of access to health care generally, especially for minorities and low income populations. When we look at health status, we find a higher infant mortality rate, higher HIV infection, higher teen pregnancy rates, more hypertension, diabetes and other chronic diseases which reduce life expectancy as well as the quality of life. For the period of 1984-86, infant mortality for Whites in

Connecticut was 8.5/1,000 live births, while for Non-Whites this number was 17.4. However, this is not the complete story, for in some inner-city communities, the IMR was 20/1,000. Low birthweight is a major health problem associated with lack of access to care. For the period 1984-86, low birthweight rate for Whites was 5.5 percent while the rate for Non-Whites was 12.3 percent. Some other health status indicators are the following:

Birth to Teens -	In Connecticut the percentage of births to teens is three times the rate for Whites.
Syphilis -	There was a 70 percent increase for the three-year period of 1984-87.
AIDS -	Blacks and Hispanics account for 52 percent of diagnosed cases, while representing only 11 percent of the state population.

It should be noted with some degree of alarm that many conditions identified as being more prevalent in low income populations are preventable, treatable, or controllable through adequate primary care. Thus the need for care is obvious. The lack of access is painful, wasteful and takes its toll on too many low income Americans.

The Present State of Primary Care for Low Income Populations

Primary care for low income populations is fragmented and underdeveloped. There is a reluctance on the part of private providers to serve the

Medicaid and uninsured populations. There are language and cultural barriers. Inadequate transportation is often a barrier for many people. Often those providers who serve the populations are over burden and individuals experience a long waiting time before getting services. There are 64 census tracts in Connectiout that are designated medically underserved and/or health manpower shortage areas. There would likely be more if a statewide analysis were done at this time.

If we define populations at risk for 1.) poorer health status, and 2.) lack of access as those persons at incomes below 85 percent of federal poverty level, there are approximately 592,238 persons, or 20 percent of the state population in this category.

If we look at the major urban centers in the State, we find the following:

New Haven	45%
Hartford	46%
Bridgeport	38%
Waterbury	30%

The Uninsured in Connecticut

The uninsured are a major segment of the low income population. It is estimated that 352,000 people are uninsured in the state based on a 1987 survey. Another 200,000 individuals are on Medicaid and City Welfare. This translates into about 11.3 percent of the population. However, approximately 16.5 percent of the Black and Non-White population is uninsured.

Of the above total, 120,000 individuals are in the age category of 0-19 years, 34 percent of Connecticut's uninsured; 133,000 are in the age category of 20-29 years, 38 percent of Connecticut's uninsured. In summary, these population groups represent 72 percent of the state's uninsured.

Nationally, it is estimated that 78 percent of the uninsured are either workers or dependents of workers according to the Employment Benefits Research Institute, 1986. Approximately 32 percent of the total are children.

In the U.S., 53 percent of children in poor, single parent families were uninsured in 1986.

Forty-three percent in poor two-parent households were uninsured in 1986.

Impact of Uninsured Status on Health Care Access/Utilization

Insurance Coverage	Mean # of Physician Visits - 1986	Percent Hospitalized
Uninsured	3.2	4.2
Insured	4.4	5.7
Gap	-27%	-19%

Clearly there is an access problem which translates to a lack of primary care and prevention services.

The Role of Community Health Centers

There are currently ten community health centers in the Connecticut Primary Care Association. The Centers have been described as the best and most effective model for serving urban and rural low income populations. Some of the distinguishing characteristics of health centers are the following:

- They are community based - located in the underserved neighborhoods.

- In Connecticut, the centers are located in cities/towns with 19 percent of the total population, but with 32 percent of the population below 185 percent of poverty.

- The centers serve low income populations - 80 percent of the population served in the State are below 185 percent of the poverty level.

- The centers are comprehensive - they provide a wide range of medical, dental and health related services; often through multiple sites, mobile clinics, etc.

- The clinics are accessible - clinic hours include nights, weekends and appropriate arrangements for working individuals and families. The centers eliminate cultural, language, financial, attitudinal and other barriers to care.

- The centers are responsive to their communities - they provide special programs to address ongoing and new health problems, e.g. homeless, substance abuse, teen pregnancy, AIDS, hunger, infant mortality, hypertension, diabetes, etc.

- Centers promote preventive health care and appropriate use of the hospital emergency rooms.

- Centers have improved the health status of the populations served. They have reduced infant mortality, rheumatic fever, middle ear infections, and increased the immunization rates.

- The centers provide high quality care - the centers provide a case-managed approach to care: there is outreach, followup and continuity.

- The centers are efficient and cost effective - the number of people served has shown a dramatic increase while funding levels have grown at a very slow pace. Centers have been skilled in generating other revenues to support the increased demand for services. A part of the center tradition is to make effective and judicious use of other health professionals, support services, etc. Several studies have shown that centers have cut hospitalization rates by 44 percent, hospital days per patient by 62 percent and average length of stay by 34 percent. Centers also control the cost of hospital care.

- The centers are family-oriented in their approach to care.

Who is Served

In 1988 - 66,250 persons with over 275,000 patient encounters.

Racial/Ethnic Mix - 82% Black and Latinos.

Women and Children - When combined, women of child bearing age (15-44 years) plus children age 14 or younger account for approximately 70 percent of visits.

Insurance Status

Approximately 25 percent of all visits (1987) were to uninsured individuals.

This figure has likely increased.

At two centers, over 40 percent of visits were made by the uninsured.

In summary, the need for care has been well documented. There are critical problems with access. The level and size of the uninsured population deserve much more attention, however, the impact of the problem is serious and a resolution must be found immediately. While community health centers play an important role in serving the uninsured, there are towns in Connecticut with more than 20 percent of their populations at incomes below 185 percent of poverty and in great need. Additionally, the current centers face significant challenges - surge in demand for care, stagnant or declining resources, shortage of available personnel (medical), high malpractice premiums, and inadequate Medicaid and Medicare reimbursement rates for selected services.

There is an urgent need to invest in a system that assures that primary care is available and accessible to all citizens.

Thank you.

Mr. MORRISON. Thank you. And I want to thank all three members of our panel for their testimony.

Dr. Klerman, if I could start with you and ask a few questions.

As I understand the thrust of your testimony, we ought not to believe that merely creating universal financing for access to health care will solve all of our health status problems. And you have spoken in terms of children, but I assume that that probably also could be generalized to some degree. At least, the population as a whole. But would it be fair to say that your testimony also said that that kind of universal access is a necessary condition to getting at the problem?

Dr. KLERMAN. It would be eminently fair. This country needs universal access to health care, as well as other services. However, my field of expertise is women and children, and the name of this Committee is Children, Youth, and Families, so, I have taken the liberty of restricting my comments to that area.

I do not think there is any doubt, and I am sure the gentlemen on my left and my right, representing financing and primary care delivery, would agree that in the absence of a more equitable funding arrangement, community health centers and other primary care facilities cannot survive and provide essential services. These facilities need more patients who can pay through public or private insurance. And women who do not have insurance are less likely to seek prenatal care, and children who do not have insurance are less likely to be adequately immunized.

As a long standing advocate for children, I am in favor of equity. But as a public health person, I must also look at health status. Health status is not only modified by medical care. In public health, we believe that the environment influences children's health, possibly more than that of other age groups.

Universal access is urgent and we cannot move ahead without it; but by itself it will not solve the health problems of many children, especially poor children. We will be medicalizing social problems.

Mr. MORRISON. Is there not a problem then that goes beyond merely the health care issue in the narrowest sense—or the medical care issue in the narrowest sense, of our decision to look at needy populations as somehow separate and different, and to be reimbursed at lower rates, and to generally be treated as if their access to care is of a lower order of priority to be presented to only certain practitioners out of the population that are available, and only certain institutions. So, doesn't our equity concern; that is, that the system would think of the health of all the citizens as part of the same system, rather than the system over here for the people who have, and the system over there for the people who have not, isn't that also part of our problem?

Dr. KLERMAN. Theoretically, we are all in favor of a one track system under which all would seek medical care from the same group of providers; all providers would be paid the same, regardless of whom they saw, and providers would ask the same amount of all patients. Unfortunately, I cannot see that in the immediate future for America. Meanwhile, I am concerned about the health care of children and, particularly, poor children.

Mr. MORRISON. Then wouldn't it make sense to pay more for providers of care to poor children and poor families—who have bar-

riers to care because of transportation problems or education problems or problems that have accrued over maybe even generations in some of these families—rather than the opposite?

Dr. KLERMAN. That certainly is true, but the other issue is the one that Mr. Scott mentioned that poor families need a different package of services. As long as there is poverty, as long as there are vast cultural differences within our country, we cannot expect that office-based providers are going to provide the services that many of these groups need. Therefore, we will continue to need community health centers, health departments, family planning clinics, and school-based clinics. These are the things that are touched upon in my testimony.

Mr. MORRISON. But there are few or fewer office space providers to the population as a whole, isn't that true?

Dr. KLERMAN. Pumping more money into the system through insurance will move more children into office-based practices, but not all poor children.

Unless we continue to support the kind of services that Mr. Scott's Hill Health Center provides, we will be spending a lot more money and many people will receive services; but first priority may not be the pregnant women and children in whom America has the longest range investment. We should have learned this from our experience with Medicaid.

Mr. MORRISON. I will yield to the gentleman from Illinois to ask some questions, and then I will come back for a second round.

Mr. EVANS. I think one of the most disturbing things that we have in our country is this increase in infant mortality rates. And either Mr. Scott or the Committee has given us statistics to indicate that generally infant mortality is up in Connecticut much higher in minority communities and so forth, and I wondered why that was happening?

Is it largely related to the fact that Dr. Thorpe has pointed out that a good many women are not receiving prenatal care, or is it related to the other environmental factors that you have indicated, Dr. Klerman, in terms of the conditions that poor people face?

And if it is related to the prenatal, the lack of prenatal care; and I understand that is a problem at the Fair Haven Clinic, and I would assume at the Hill Clinic as well, how do we reach those people? Is it more resources to educate women? Is it more resources in the programs to reach the women coming into the clinics?

I am giving you kind of a broad-based essay question here, but I would like you to focus, all three of you, on those issues if you could for a few minutes?

Mr. SCOTT. I think that, Mr. Evans, it is all of the above. We find that the problem is more complicated than we had anticipated for a number of reasons.

First, it has been somewhat difficult to get providers to serve the population. And it is not that there are not those committed individuals, but the cost of malpractice insurance has been extremely high. For instance, in our own setting, we are paying about $80,000 per OB now. And that is an incredibly large sum of money. We are fairly well staffed at this point in time.

The other point is that, and the reason why I referenced the one stop shopping bit, that there are things that we learned from the

'60s that helped us serve this population very well, but it was difficult to hang on to due to Federal budget cuts and the changes of emphasis and priorities. For instance, we are going back now to the case management and outreach effort, which we knew was very important and effective on social work. There is again emphasis on the case management. All of these things make a difference.

However, we are faced now with two other devastating problems. They are AIDS and substance abuse. Some of the infants that are born now will end up as orphans very soon because their mothers will die of AIDS. We are seeing some of this already. So the problem is extremely complicated.

We have also had to address the issue of adequate compensation for our providers. There is concern around long term disability. We have not had an impact on poverty which, obviously, is the basic cause of many, if not all, of the problems we face and provide a model for care.

It is our experience that we can impact favorably on infant mortality if we have the elements in place, and we are doing that. But at the same time there is much more that we need to do to cover the entire city. And to do that, more resources would be needed.

I think we have also tried to address the inadequate reimbursement rate through medicaid as well while the reimbursement is still inadequate for the prenatal package, it is now little more conducive. We started with the visits. At one time, there was a limit on the number of prenatal visits, not to mention the inadequacy of the rate. This has changed a bit, but we still need to look at labor and delivery costs, and other kinds of services.

We have to also address the hunger issue or malnutrition as well. Nutrition has to be an essential service element. We do a lot in trying to get the pregnant woman to stop smoking, which we know impacts negatively on outcome. There are a number of things that we have to do in risk assessment and prevention. The model is there. The resources are not always there.

Dr. KLERMAN. First of all, infant mortality rises and falls in New Haven on a yearly basis, but over the United States as a whole, infant mortality is very slowly declining. The problem is that it is going down at a much slower rate than it did in the past, and the current crack epidemic may cause an increase.

I can summarize the medical care problems faced by women and children in three words—financing, capacity, and content.

The Institute of Medicine in its report, *Prenatal Care: Reaching Mothers, Reaching Infants* noted that when you ask women what is the main reason that they sought prenatal care late or not at all the first reason is almost invariably that they did not have enough money. So, the problem of financing care is still number one.

But the second problem is capacity. Relatively few private obstetricians accept Medicaid or large numbers of Medicaid patients. As I go from city to city, and state to state, studying these problems, I am told about six week waiting lists for clinic-based prenatal care. Such a wait is bad if you are hypertensive, but you are likely to be hypertensive for the next twenty years; pregnancy, however, only lasts nine months. If you have to wait six weeks for care, you may already have passed the period during which prenatal care can have maximum impact.

So, there are real capacity problems both in the private and the public sector.

And, third, I was privileged to serve on the Public Health Service's Expert Panel, on the Content of Prenatal Care whose report was released in October. It stressed the psycho-social components of prenatal care. We can look at prenatal care from a very medical point of view, but the evidence suggests that the services that make the most difference are smoking cessation, alcohol abuse prevention, and family support. In most states it is difficult to convince Medicaid or any insurance program to pay for such services. Therefore, this routing relies on health departments and community health centers to provide those services out of their basic support grants. When their basic support grants are cut or do not increase relative to medical care inflation or the number of people served, these are the first services cut. The obstetricians stay; but the outreach workers, the nutritionists, the social workers, the home visitors are dropped. Prenatal care does not improve and infant mortality does not decline.

Dr. THORPE. Financing is clearly important, and that is probably in terms of a first step. That is the first initial step that would have to be taken. But to give you a couple of examples of why that is not sufficient.

If you look at a state like New York, which I have spent a lot of time studying, New York state has, New York City, for example, has by far the most expansive public hospital system in the country.

The public hospital system there provides over half of the ambulatory care in the city. It provides for one-fourth of the in-patient admissions in the city. Generally, for the uninsured, there are few payment requirements. And they do pride themselves on trying to provide universal access to low income individuals.

But if you look at the combination of the help in the Health and Hospitals Corporation, a fairly expansive Medicaid program in terms of the percentage of the poor that they cover, a $400 million per year bad debt and charity care fund, which explicitly finances bad debts that hospital's incur in the voluntary system for providing care to low income patients; that despite that patchwork of financing systems that are in place, the types of care that—primary care in particular, that low income individuals receive is still fully inadequate.

Much of it is because of the fact there is a capacity issue that much of the primary care is institutionally based. People come in really when they are sick, rather than to come in and receive primary and preventive care, basically because they would have to wait an awful long time to ever receive any services. The waiting times in outpatient departments and emergency departments in those hospitals are very very long and are basically triaged out of the system.

So, financing is necessary, but as that state is trying to embrace right now, reorganization of how primary care is delivered in the system is probably as, if not more, important.

Mr. EVANS. All right. I do not really have any other questions. Just, Dr. Klerman, I want you to know that this Committee under George Miller and Bruce Morrison's leadership has looked at a lot

of the other issues that you have talked about, which we think are vitally important--violence in families in terms of housing programs. We know that there are real needs if we are going to reach out and address the problems that the poor people in particular face. So, we appreciate you bringing them up. But I wanted to assure you that we have been focusing on those issues as well.

Mr. MORRISON. Dr. Thorpe, I wanted to ask some questions about your statistics, and also about your studies of alternative strategies for improving financing access.

First, with respect to your breakdown of the source of costs in the system. You identified 39 percent of the change in costs from 1987 to 1988 as a result of changes in service intensity, meaning more procedures and more technological innovations being employed.

To clarify, when you say that 52 percent of it is inflation, increase in prices, what kind of prices do you mean, and what do you use as the base to make that determination?

Dr. THORPE. Well, that is a real problem, but basically what it is is underlying changes in wages, and underlying changes of nonlabor inputs—the cost of capital, electricity, and so on.

Mr. MORRISON. But this is medical inflation rather than societal inflation. Doesn't this medical inflation tend to be higher than the CPI generally?

Dr. THORPE. Yes.

Mr. MORRISON. So the data does not answer our question of why it is that costs in the medical sector go up faster than costs go up generally either, does it?

Dr. THORPE. Well, I think that is a real important research issue. We really do not have a really good index of medical care price inflation. What we have is an index, which essentially looks at year to year changes in hospital and physician charges, which is not really a price index because those charges are never really paid by most of the population.

So, if you did look at sort of the actual changes in costs, which we do not have, that is not what the medical care CPI does, it would still be higher, but how much higher than the CPI is not clear.

Mr. MORRISON. I know, but if you ask people why medical costs go up, many would cite certain compensation issues, some of which are caused by shortages. Certainly, the nursing shortage has had a big impact here. But when we talk about drug prices or the cost of high technology, we really do not know very much about the extent to which the price increases beyond general societal inflation are justified.

In other words, we should not just pass over the half of the cost increases distributable to inflation and say, "Oh, well, there is nothing we can do about that." We do not know the real effect of monopolistic forces, unregulated pricing, and other factors in this area. Therefore, we should not just assume that this inflation figure is incapable of being regulated out of the system even if there is an effective financing mechanism that looks closely at what these costs or their benefits really are.

Dr. THORPE. I think that is a fair statement. If you look at that figure, and looked at a couple of states. And, again, just because I

know, the New York numbers pretty well, that the rate of increase in underlying wages and cost of capital and non-labor inputs there is not a whole lot different than the CPI.

Mr. MORRISON. Let's go to the most startling chart, Table 3. You demonstrate a dramatic difference in what I take to be utilization of various kinds of procedures and equipment between the United States as compared to Canada and Germany.

First, just let me clarify that this table is of the incidence of use of these items?

Dr. THORPE. These are just units actually, so, these would be MRI scanners, open heart surgeries.

Mr. MORRISON. So, in other words, these are facilities to do this?

Dr. THORPE. Facilities, right.

Mr. MORRISON. So, this does not tell us the intensity of use?

Dr. THORPE. This is not even the utilization side, which would make it much more dramatic.

Mr. MORRISON. So, this is just the capital expense——

Dr. THORPE. That is correct.

Mr. MORRISON [continuing]. Not the incremental expense of using it time after time? We have to finance the capital expenditure before we can even begin to wonder about the question of using it. What is your observation about this? Is there any pay off for this dramatically higher capacity for these kinds of more sophisticated interventions?

Dr. THORPE. Well, there are clearly payoffs to having the technology available. I think the issue is what is the payoff from having it so widely distributed. I mean, it does serve a benefit in the sense that it provides access to patients in community hospitals so that they do not have to travel to regional medical centers, for example, so, there is a benefit in that sense.

From what I can tell, there are good reasons why the United States has different rates of diffusion. Two basic reasons.

One is there is no mechanism by which the United States regulates or monitors either the adoption or the diffusion or use of technologies in this country. It is one of the most surprising facts I think that you would ever see if you look at the literature, that the technologies come on line with no studies of clinical or cost-effectiveness. They come on line without randomized clinical trials to understand their effectiveness, let alone their cost effectiveness.

So, that is just generally not done. And they are so widely disbursed because of concerns about medical malpractice issues. Many hospitals have access to a lot of the technologies in order to just keep up the local standards of care.

Mr. MORRISON. Well, it is almost a religious belief in this society that the existence of these technologies and investments make us healthier. In the Hartford Current yesterday, there was an article by the executive director of the Connecticut Medical Society. He argued that the reason that health care costs more in America is that ours is better and we have more of it. He was delighted to note that health care was almost to 12 percent of the GNP and expanding. He felt it was wonderful that health care is growth industry. I think his view is at odds with the belief of most Americans, and yet I found it almost shocking.

My question is, what would be the cost of changing our reliance and what would cause it to change? And in your research, why have insurance companies not caused this oversupply to change?

Dr. THORPE. The only insurance company that does look at these technologies in a broad base way is the National Blue Cross/Blue Shield Association, which does have a very formalized technology assessment capacity.

The problem though is that by the time they make their technology assessments the units are already out in the field. And they are making decisions about whether or not they are going to reimburse for MRI scans of the knee or elbow or whatever. So, they are really looking at very marginal reimbursement decisions after the new technologies are already out in the field.

It has to do—there are a couple of major problems with it. And I will focus on imaging technologies because those are some of the most widely growing new technologies that are available.

a. We do not have the studies which do prove their cost effectiveness in large part because most of the people who do the studies rarely compare costs and benefits. The notion of comparing diagnostic benefits to how much the technology cost just has not been done in this country.

The way the Canadians and the way that some states that have central large rate setting have limited the diffusion of technology is by planning. They are just rationed. For example, New York state as of three years ago had less than 12 MRIs in that whole state in hospitals despite the fact that that is by far and large the largest center of teaching in the country. And that happened because the state Health Department has a very similar planning function, if you will, that the Canadians do. So, they just limit the diffusion of the number of units out in the field.

Mr. MORRISON. I know that you have studied the new New York approach and some others. Could you briefly give us your critique of the major differing strategies that we see being proposed for providing access, including Medicaid expansion and Medicaid buy-in; mandates to employers; and some universal insurance approach, which socializes the insurance function in some more broad based way, rather than for a target population?

Dr. THORPE. The two major differences that I can see is, each of those approaches extend health insurance coverage to different numbers of individuals. The pure public sector approach is that the expansion, and the buy-in, provide coverage for the lowest end of the income spectrum. And arguably, those are the individuals where those expansions should be focused initially.

So, the types of expansions, up to 200 percent of poverty line, for example, would take care of almost ⅔ of the uninsured, or at least provide a financing mechanism for ⅔ of the uninsured. It would leave a number of working families above 200 percent out.

So, the first difference, is just the number of individuals that would be picked out. If you just did an employer mandate without any public sector role, then that would also pick up about ⅔ of the uninsured in the country, but it would leave——

Mr. MORRISON. A different ⅔?

Dr. THORPE. Yes, a different ⅔, and it would leave about 6 million poor people without health insurance coverage because they are not either full time workers or not employed.

So, those are the differences. You would cover different segments of the income population and the age distribution with these approaches. And that is why I think that there has been some interest in coupling these approaches because you could, depending on how you wanted to structure it, provide insurance coverage for everyone.

The second difference I see with them is who pays? There are three candidates: employers, employees individuals if they are not working, and governments. And each of these approaches that we just identified allocate different distributions of who is going to finance health insurance expansions.

So, the pure public sector approach is, as it sounds, would be very focused on the federal government, State governments, and in some cases, local governments. Employer mandates would have costs assigned more broadly to employers, individuals, employees, and in some instances, governments.

Mr. MORRISON. But when employers provide health insurance, they charge a good portion of it to the public sector through tax deductions, and they pass the remainder either back to their stockholders or forward to their customers in one way or another. These corporate entities allocate the cost one way or another, through either lower profits or higher prices.

So, at some level, we are already distributing most of these costs to the public. While we seem to get into rather complicated distribution discussions that miss the point, at the end of the day, the society as a whole is paying this 11 plus percent of the GNP.

Dr. THORPE. Well, I think that you can discuss the incidence of this in some length. But if you look though at the population that we are talking about, ⅔ of Americans who are uninsured and who have a work place connection, the thing that is characteristic about this population is that ⅔ of them are low income. That is, they work in jobs that pay low wages, and in many many instances minimum wages.

And I think that some of the policy debate that you hear about is from employers who employed them, whether they are in small firms or that are marginal new firms, the ability to make the price adjustments forward is limited. And they view this as a pure profit reduction. It is sort of a traditional economic tenant that the new insurance costs are passed on through a reduction in other forms of compensation.

Just, for example, if there was an employer mandate, which is along the lines that Senator Kennedy and Congressman Waxman have proposed, which mandated a very limited benefit package in many ways, would add about 60 to 70 cents an hour to a low wage worker at $3.35 right now. And the concern is is that if employers cannot pass that forward, and it cannot pass it back by definition, since these workers are at or near the minimum wage, that there could be some concern over employment.

Now, neither of those caricatures of how this works is right. And there is some sharing of the burden of this. But I think your point is a good one because it is true that even though we have an em-

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ployment based system, a lot of the costs of providing health insurance is in part disbursed throughout the economy through the pricing system, through prices of final products.

Mr. MORRISON. One last question. And that is, a number of the individuals who are going to testify later have made a particular attack on so called mandates. Frankly, I have some sympathy with the general anti-Kennedy/Waxman concern, because it does reach at the level of marginal employees and employers, and may be totally impractical at the end of the day in terms of really getting at the problem. But these attacks are much broader, and they are on mandates with respect to the range of coverage that any private insurance must cover.

But how do we pay for the non-mandated services? Can we realistically talk about universal coverage in any way and not one way or another manage to mandate the package that we have? Further, is there any way that we can get our arms around the cost of the system if we do not mandate what it is that can and cannot be paid for?

Dr. THORPE. I will try not to take too long with that. I think that it is a good opportunity to talk about New York's new proposal. And I think it has a number of problems, but I think it is interesting in a couple of respects.

First, what they are proposing is that the state be a single payer. So, that gets directly at the issue of resource growth over time. It does not eliminate the private insurance industry in the sense that New York state would simply negotiate rates across the board. Private insurers would still have some role to compete on managed care and on scope of benefits subject to a floor of benefits or an actuarial equivalent that they have to provide. So, that is one approach, to have a single payer, which is out negotiating across the board for rates.

The second, which is intriguing, and it is also very important, is that it would provide universal coverage in the sense that everyone would receive a UNY-CARE card. In essence, the provider would be blind with respect to whether it is a Medicaid, a UNY-CARE person, Blue Cross, or whatever. Everybody would have the insurance card. And UNY-CARE then would be billed for services by hospitals and physicians, which are negotiated by Unicare.

So, the three things which are a little bit different, is that:

1. It does provide universal coverage, which is similar to some of the proposals, the Kennedy/Waxman and others that have been talked about; but

Secondly, it has the universal aspect to it in terms of making the providers blind to coverage.

And, third, there is a single payer. So, I would characterize it as a middle ground between some of the provincial models that the Canadian's use, and what we have now.

Mr. MORRISON. Thank you very much. I want to thank all of you on the panel for your testimony. We are going to take a very short recess, and then convene with our second panel.

[Whereupon, there was a short recess.]

Mr. MORRISON. I would like to call the next panel at this time. Sister Anne Virginie, who is the Chairperson-Elect of the Connecticut Hospital Association and the President of the Saint Raphael

Healthcare System in New Haven; H. Craig Leroy, the President of the Insurance Association of Connecticut in Hartford; Richard Holdt, Vice-President of Marketing, Blue Cross/Blue Shield of Connecticut in North Haven, Connecticut; and Janet Spegele, Vice-President of the Legal Department at the Connecticut Business and Industry Association, Hartford, Connecticut.

Thank you all for being here. Your written statements will be made a part of the record in full. And we will start the testimony with Sister Anne.

STATEMENT OF SISTER ANNE VIRGINIE, CHAIRPERSON-ELECT, CONNECTICUT HOSPITAL ASSOCIATION; PRESIDENT, ST. RAPHAEL HEALTHCARE SYSTEM, NEW HAVEN, CT

Sister VIRGINIE. Thank you. As you stated I am, and this is for the record, Sister Anne Virginie, the President of the Saint Raphael Health System, and I am also currently Chairperson-Elect of the Connecticut Hospital Association.

Like my colleagues here this morning, I really am grateful for the opportunity to address you, and to thank you, Bruce, for bringing the hearing to New Haven. The setting is apt. Like many cities in America, it is a paradox. On the one hand, it is rich in cultural, educational, and medical resources. It has two large and highly sophisticated hospitals, a renowned school of medicine, many fine community health clinics and agencies, one of the nation's highest ratios of doctors per thousand population, and nearby a large veterans hospital.

On the other hand, we have an infant mortality rate of a third-world country at more than 17 deaths per thousand, and for blacks alone, more than 26 deaths per thousand. This, as compared to the United States rate of more than 10, which is widely criticized as only eighteenth among industrialized nations. You heard discussion about the infant mortality situation in earlier testimonies.

The existence of medical technology, even in the hands of the well meaning, will not help if access to it is not assured. Taken a step further, the causes of infant mortality and many of the other more serious health problems facing our nation are not health care or the lack of it, but problems rooted in poverty, lack of education, and ignorance.

If only we could address all of those problems. But that is neither the purpose of this hearing, nor is it possible in the time allocated today. The issue today is access and funding. Very simply, and you have heard this before, 37 million uninsured and underinsured Americans live without essential health care services. How sad and how tragic for our nation.

As a humane and just people, we should want life to be better for all of our sisters and brothers, and especially for all children. If that is not reason enough, we should want better care for them because their improved health will improve the strength and vitality of our nation.

A good beginning can be found in the following statement by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: "Society has a

moral obligation to ensure that everyone has access to adequate care without being subjected to excessive burdens."

Behind that beautiful, simple statement is an incredibly complex problem whose best solutions are wickedly expensive. It is a difficult time to talk about universal access. Health care costs continue to rise while virtually every level of government is beset with fiscal problems. The temptation is to push the problem under the rug once again and keep patching up a system that is not working.

But that is not good enough. We can change the situation if we are willing to commit to more than just words that access is assured. Most hospitals find themselves with the every day financial reality behind that noble concept.

Government is regulating, but not innovating.

It assures access, but it does not pay its fair share.

It looks for answers to new problems, but turns away from the old ones that are still very present.

Building a new system on a crumbling foundation really does not make much sense.

It would seem that we might begin in two ways. First, efforts should be aimed at making it possible for more people to be insured, or to have their care paid for. Second, we should put more responsibility into their hands for the cost of their care, and provide incentives for preventive care and wellness. And, finally, but certainly not least, we should assure that providers are fairly compensated for their services, and that payment systems are not working over time as regulatory or cost control systems. Both may be necessary, but not as one in the same.

For many years, major third-party payers indirectly subsidized the cost of caring for the poor. But the gap between the cost of providing care to Medicare and Medicaid patients, for what hospitals and other providers get in payment, grows wider and wider. Medicare payments have risen only half as much as the cost to provide the care. Meanwhile, employers are understandably working aggressively to restrain health care benefit premiums, and insurers are responding in kind.

Hospitals are both worried and frustrated. The old saying, "There is no such thing as a free lunch," comes to mind. Someone indeed has to pay.

And, yes, hospital care is expensive. But not entirely because of inefficiency. The services and technology, and the complexity of care in today's hospitals cannot be compared to the past. Not even the near past. It is not just expanded services. There are the big costs related to AIDS and universal precautions, disposing of infectious medical wastes, and the continued critical shortage of nurses and other allied health professional staff.

Simultaneously, we are seeing patients who are more acutely ill than ever, and who require higher levels of intense hospital services. The hospital in our health care system locally has the highest case mix intensity of any in Connecticut, and it is one of the top 50 of the nation's 6,000 hospitals.

By being less able to shift costs to private insured patients, and with reduced government support, hospitals are less able to pay for care of the uninsured poor, just as the number of the uninsured poor increases. And most hospitals never turn away poor patients.

Those hospitals, along with others, in inner cities share a disproportionate share of the cost of caring for the poor. And, finally, hospitals with large numbers of Medicare patients shoulder still another burden.

I do not mean to be all gloom and doom, or to present only the problems of one portion of the entire system. But reality must be acknowledged before we can create new expectations, or want hospitals to do more.

Nor do I discourage you from innovating. Government already has proven that it can substantially improve health care services to the poor and the elderly. Both groups achieved dramatic improvements in access to health care after the introduction of Medicare and Medicaid.

Two short term strategies are available to improve access. The first and simplest is to insure the health care of the poor. The second is to pay hospitals or other providers directly to care for the poor. Expanded public insurance is clearly the superior of the two.

Insurance coverage encourages people to obtain necessary health care who otherwise could not afford it, or who would not seek it.

Coverage could be improved by expanding both Medicaid and state mandated private insurance. Many believe that all poor people are covered by Medicaid, even though the program covers only about 31 percent of the poor.

Expanding both Medicaid's eligibility requirements and its benefits would be a big help. Congress should set a national income standard to increase the number of poor persons eligible for Medicaid. Although states could choose to set higher income limits, no state would be permitted to deny Medicaid benefits to those with incomes at or below the Federal standard. The eligibility standard should not be less than 75 percent of the Federal poverty level.

Also, many persons with Medicaid coverage have difficulty finding a participating physician. Persons eligible for Medicaid may find it necessary to use emergency rooms for non-emergencies. This is understandable, but it is also costly and inefficient. States whose Medicaid physician reimbursement rates discourage physician participation should offer higher such rates.

The second strategy, that is, paying hospitals directly to serve the poor, is less efficient since it only covers care in hospitals, the most expensive site for care. But the reluctance of the Federal or state government to insure all the poor makes development of programs to pay hospitals directly one of the few politically viable means for improving access to health care. Under this idea, the financial burden would fall disproportionately to certain providers, depending on their location and commitment to rendering such care. Facilities providing substantial free care should be targeted for increased reimbursement.

Many families could be helped by mandated private insurance for the newly unemployed and the working poor.

The long term solution for the poor and their families is to reform Medicaid, the largest U.S. welfare program. And I would refer this Committee to two contrasting resources and philosophies, both of which make brave and intriguing recommendations beyond my expertise to personally present to you today.

The first is a 1986 document entitled, "No Room in the Marketplace: The Health Care of the Poor", the final report of the Task Force on Health Care of the Poor of the Catholic Health Association in the United States. The task force presents thoughtful short, and long range strategies, and specific recommendations to assure equal access by all to the United States health care system.

The second resource is the 1989 document, "Critical Issues, a National Health System for America", published by the Heritage Foundation. I am not a political conservative, but I am intrigued by many of this book's ideas for reforming and funding a health care system that achieves the goal of equal access. It stresses flexibility, decentralization, innovation, and incentives for experimentation.

Copies are available, and I have listed the address in my testimony, and I brought copies to take with you should you be so inclined.

I appreciate your willingness to hear me, and especially of you, Bruce, to help us bring this hearing to New Haven. Thank you again for inviting me.

[Prepared statement of Sister Anne Virginie follows:]

PREPARED STATEMENT OF SISTER ANNE VIRGINIE, PRESIDENT OF THE ST. RAPHAEL HEALTHCARE SYSTEM, CHAIRPERSON-ELECT OF THE CONNECTICUT HOSPITAL ASSOCIATION, NEW HAVEN, CT

Good morning. I am Sister Anne Virginie, President of the Saint Raphael Healthcare System here in New Haven. I also am Chairperson-Elect of the Connecticut Hospital Association.

Thank you for the opportunity to address you, and for bringing this hearing to New Haven. The setting is apt. Like many cities in America, it is a paradox. On one hand, it is rich in cultural, educational, and medical resources. It has two large and highly sophisticated hospitals, a renowned school of medicine, many community health clinics and agencies, one of the nation's highest ratios of doctors per thousand population, and--nearby--a large veterans hospital.

On the other hand, we have an infant mortality rate of a third-world country at more than 17 deaths per thousand and, for blacks alone, more than 26 deaths per thousand. This, compared to the U.S. rate of more than 10, which is widely criticized as only eighteenth among industrialized nations.

The existence of medical technology--even in the hands of the well-meaning--will not help if access to it is not assured. Taken a step further, the causes of infant mortality and many of the other most serious health problems facing our nation are not health care or the lack of it, but problems rooted in poverty, lack of education, and ignorance.

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But that's not good enough. We can change the situation if we are willing to commit to more than just the words that access is assured. Most hospitals find themselves with the every day financial reality behind that noble concept.

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Building a new system on a crumbling foundation doesn't make much sense.

I would begin in two ways. First, I would make it possible for more people to be insured or to have their care paid for. Second, I would put more responsibility into their hands for the cost of their care, and provide incentives for preventive care and wellness. And finally, but certainly not least, I would assure that providers are fairly compensated for their services and that payment systems are not working overtime as regulatory or cost control systems. Both may be necessary but not as one in the same.

For many years, major third-party payors indirectly subsidized the cost of caring for the poor. But the gap between the cost of providing care to Medicare and Medicaid patients, and what we get in payment, grows wider and wider. Medicare payments have risen only half as much as the cost to provide the care. Meanwhile, employers are understandably working aggressively to restrain health care benefit premiums, and insurers are responding in kind.

Hospitals are both worried and frustrated. The old saying, "There's no such thing as a free lunch," comes to mind. Someone has to pay.

And, yes, hospital care is expensive. But not because of inefficiency. The services and technology and the complexity of care in today's hospitals cannot be compared to the past, even the near past. It's not just expanded services. There are the big costs related to AIDS and universal precautions, disposing of infectious medical wastes, and the continued critical shortage of nurses and other allied health staff.

Simultaneously, we are seeing patients who are more acutely ill than ever and who require higher levels of intense hospital services. I know this

problem firsthand. My hospital has the highest case mix intensity of any in Connecticut, and one of the top 50 of the nation's 6,000 hospitals.

By being less able to shift costs to private-insured patients and with reduced government support, hospitals are less able to pay for care of the uninsured poor--just as the number of uninsured poor increases. And most hospitals are like mine in never turning away poor patients. Those hospitals along with others, also like mine, in inner-cities share a disproportionate share of the cost of caring for the poor. As the final whammy, hospitals like mine with large numbers of Medicare patients shoulder still another burden.

I do not mean to be all gloom and doom, or to present only the problems of my niche of the system. But reality must be acknowledged before we create new expectations, or want hospitals to do more.

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Expanding both Medicaid's eligibility requirements and its benefits would be a big help. Congress should set a national income standard to increase the

number of poor persons eligible for Medicaid. Although states could choose to set higher income limits, no state would be permitted to deny Medicaid benefits to those with incomes at or below the Federal standard. The eligibility standard should not be less than 75 percent of the Federal poverty level.

Also, many persons with Medicaid coverage have difficulty finding a participating physician. Persons eligible for Medicaid may find it necessary to use emergency rooms for non-emergencies. This is understandable but also costly and inefficient. States whose Medicaid physician reimbursement rates discourage physician participation should offer higher Medicaid rates.

The second strategy--paying hospitals directly to serve the poor--is less efficient since it only covers care in hospitals, the most expensive site for care. But the reluctance of the Federal or state governments to insure all the poor makes development of programs to pay hospitals directly one of the few politically viable means for improving access to health care. Under this idea, the financial burden would fall disproportionately to certain providers, depending on their location and commitment to rendering such care. Facilities providing substantial free care should be targeted for increased reimbursement.

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Copies of the documents are available as follows. The Catholic Health Association is located at 4455 Woodson Road, St. Louis, MO 63134 (telephone 314-427-2500). The Heritage Foundation is at 214 Massachusetts Avenue, N.E., Washington, D.C. 20002 (telephone 202-546-4400).

I appreciate the willingness of the Committee to hear me, and especially of Congressman Morrison to help bring this hearing to New Haven. Thank you again for inviting me.

Mr. MORRISON. Thank you very much.
Mr. Leroy.

STATEMENT OF H. CRAIG LEROY, PRESIDENT, INSURANCE ASSOCIATION OF CONNECTICUT, HARTFORD, CT

Mr. LEROY. Thank you very much, Congressman. I will try to summarize and be brief. Many of the thoughts I have are starting to be covered already.

Everyone is becoming more and more concerned about the increasing cost of health care. Employers who provide the insurance coverage are worried about their insurance premium increases. Employees are troubled by the ever increasing share of health care costs that they have to bear themselves.

But the single overriding question everyone is really asking is, why are health care costs increasing so rapidly? I wish I could say I had the magic answer to tell you today, but I do not. But I would just like to comment on a few of the factors that Professor Thorpe already mentioned—advances of medical technology, population growth, increased life expectancy, and as well as general inflation in the overall economy does have an impact.

Two of the most important factors are the changes in medical technology in the increasingly intensive use, which our figures, which are from the Health Insurance Association of America, contributed roughly 29 percent to the increased spending; and physicians who have admitted to practicing defensive medicine to guard against potential medical malpractice performing some test procedures of limited value. Between 10 to 20 percent of the tests were found to be medically inappropriate or unnecessary when reviewed by medical experts.

But insurance premiums are increasing faster than the medical inflation rate. Why is this happening? Hospitals have continued to increase rates charged to private sector patients to offset very real, inadequate governmental payments for health services. It is estimated the cost shifting will add about $18 billion nation wide to private sector health care costs in 1989.

In Connecticut, for example, hospital rates increased an average of approximate 58 percent from fiscal year '86 to fiscal year 1989. Hospitals are now requesting rate hikes for fiscal year 1990 as high as 42 percent. Since about 45 percent of the insurance premium dollar goes to pay for hospital expenses, these increases have a huge impact on insurance rates. Physicians' fees have also been rising rapidly. And besides the simple price increases, premium levels have to reflect both the volume of service if more people are using health care services more often, as well as the intensity. If more testing procedures are being performed on each individual, premiums are going to have to reflect these factors, as well as reflect simple price increases.

Claims for hospital charges represent about 45 percent of the premiums. As I said, claims to pay for doctors and dentists run about 40 percent of premiums, and administrative costs run about 11.5 percent. Profits are expected to run about 2 to 3 percent in a normal year. The 11.5 percent in administrative costs include such items as taxes paid, and services performed for customers such as

managed care and utilization review, and all the things we are attempting to do to help hold down costs.

Nevertheless, during the decade of the 1980s we saw premium increases at 6 to 8 percent annually, and into the end of the '80s we have seen increases in the double digits. We have not been alone in experiencing these rapid claim costs that are driving premiums. Both employers and unions who have self insured to a large degree have experienced similar increases in costs at their benefit package. And as insurance premiums continue to increase, individuals and businesses are more likely not to purchase insurance coverage.

And we are very concerned about the—depending upon the numbers—35 to 37 million Americans who do not enjoy the protection of health insurance. And we have been working hard to try and develop some creative solutions. And I would like to spend a few moments talking about that.

The task of ensuring that Americans enjoy protection of health insurance is very complex. And this complexity is a function of the heterogeneity of the uninsured of population. And it really does require a combination of both public and private solutions.

Just to run through the numbers that we use in trying to address this issue, we see roughly 3 in 10 of the uninsured are poor. And by that, we mean with family incomes below 100 percent of the poverty level; 3 in 10 are low income, between 100 to 200 percent of the poverty level; and 4 in 10 are non-poor, of say above 200 percent of the poverty level.

Eleven percent of the uninsured are self employed and their families, and 13 percent are half time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries, retail trade and services, and by smaller firms.

All of the above factors make devising any strategy for a solution difficult. And we need special approaches to deal with the various sub groups of population. I draw upon mostly what HIA as done in regard to the issue. And I will, again, try and be brief. I have fairly extensive written comments. But the Medicaid program clearly has to be addressed if we are to try and cover individuals who are currently not enjoying that protection.

Ultimately, we would like to see all Americans with incomes below the Federal poverty level, with limited assets, eligible for Medicaid, regardless of family structure, age, or disability status.

If available funds do not permit full coverage up to the poverty level, we believe a priority should be given first to younger children, next to older children, and finally to other populations. Priority should be placed on primary care and preventive services.

Individuals and families with incomes above the poverty level, but below 150 percent of the Federal poverty level, should be eligible to purchase some form of first dollar coverage of a limited package of primary, preventive, and related ambulatory care through their state's Medicaid program.

Such a package would help meet the near poor's need for access to basic primary care, without lessening significantly employers' incentives to offer basic insurance protection. Persons not eligible to Medicaid due to higher income should become eligible for full Medicaid coverage once out of pocket medical expenses reduce their remaining income to the Federal poverty level.

We need some sort of coverage of last resort to cover both in patient and other large out of pocket expenses for the near poor.

Under our proposal, states would have the option of buying out really two groups. First, more working people qualify for Medicaid as their income level is raised to the poverty level.

Second, current public policy supports the concept encouraging low income persons to work by easing the transition from a public support to a self support.

Insurers have a role to play in this too. Insurers should be allowed to offer more affordable coverage, including new prototype plans. Right now, ERISA preemption of state mandated benefits should be extended to insured employee plans, as it is to self insured and union plans, so that we can design less expensive benefit packages for small businesses.

We have seen Connecticut, as in elsewhere, that once the legislators start down the road of mandated benefits it seems impossible for them to stop adding new ones. Currently in Connecticut, we peg the cost of our package of mandated benefits at somewhere adding 12 to 17 percent of cost of an insurance policy. A number of different economists have tried to look at how many are uninsured because of having to offer certain mandated benefits, and ranges go anywhere from 10 up to 16 percent.

We have a responsibility in the insurance industry to make coverage available to all Americans who are able to afford private coverage. And that is true even for some of the groups whom insurers might not normally insure at this point in time due to high cost medical or occupational conditions.

We are currently both examining and will be supporting a nonprofit organization to help reinsure high cost employer groups. Employers would have access to this reinsurance organization if they are unable to purchase coverage through an insurer. And losses incurred by the reinsurance organization will be financed through the private sector.

We should also support Federal legislation encouraging all states to enact a qualified state pool for the individual who is medically uninsurable. Currently we have pools in 17 states, including Connecticut, which was the first state to adopt such a pool. And this will help ensure that everyone who wants coverage and can afford it can find it.

Finally, someone already mentioned, small businesses should be given a greater incentive through our tax vote. Specifically, to a self employed individual to purchase health insurance by getting 100 percent deduction.

We do believe that this is a real problem for our country. We are working very hard at trying to address some of the gaps in coverage. Our approach really calls for a sharing of responsibility between government and the private sector. It calls on government to assist those who cannot be expected to pay for coverage on their own, while we in turn pledge to ensure that for everyone who can afford private coverage it will be available.

Thank you.

[Prepared statement of H. Craig Leroy follows:]

Prepared Statement of H. Craig Leroy, President, Insurance Association of Connecticut, New Haven, CT

Everyone is becoming more and more concerned about the ever-increasing cost of health care.

Employers, who provide most health insurance coverage, are worried about insurance premium increases.

Employees, as well as unions, are troubled about the ever-increasing share of health insurance costs they have to bear themselves.

But the single overriding question everyone is asking is: Why are health care costs increasing so rapidly?

In 1987, the United States spent $442.6 billion on medical care -- $1,758 for every man, woman and child in this country -- and a 54.5 percent increase over the $286.5 billion spent in 1982. This burden continues to increase every year.

The growth in medical care costs has occured for several reasons -- including advances in medical technology, population growth, increased life expectancy, as well as inflation in the general economy.

Some figures from the Health Insurance Association of America, a national insurance trade association, underscore this growth in spending. Between 1982 and 1987:

--60 percent of the increased spending was attributed to inflation, the largest single factor causing health care costs to increase. As all goods and services in our economy increase in price, medical care services obviously will be influenced by these price increases also.

--10.6 percent of the escalation in health care spending was attributed to the growth in population.

--.5 to .75 percent per year was caused by aging of the population. The proportion of individuals over 65 is growing at a rate twice that of the overall population. While the elderly represent 12 percent of the total population, they account for 36 percent of the health care spending.

In addition:

--Advances in medical technology and their increasingly intensive use was found to contribute roughly 29 percent to increased spending.

--Physicians have admitted to practicing defensive medicine to guard against potential medical malpractice, i.e., medical professionals perform some tests and procedures of "limited value." Between 10 to 20 percent of the tests were found to be "medically inappropriate or unnecessary when reviewed by medical experts."

Insurance premiums, however, are increasing faster than the medical inflation rate. Why is this happening?

Hospitals have continued to increase rates charged to private sector patients to offset inadequate governmental payments for health services. It is estimated that the cost shifting will add about $18 billion nationwide to private sector health costs in 1989.

In Connecticut, for example, hospital rates increased an average 58.5 percent from fiscal year 1986 to fiscal year 1989. Hospitals are now requesting rate hikes for fiscal year 1990 as high as 42 percent. Since about 45 percent of the insurance premium dollar goes to pay for hospital expenses, these increases have a huge impact on insurance rates. Physicians' fees have also been on the rise, increasing in the CPI index some 70 percent from 1980 to

1987. Besides price increases, premium levels must also reflect both the volume of services being provided, as well as the intensity. That is, if more people are using health care services more often and more tests and procedures are being performed on each individual, premiums will also have to reflect these factors, as well as reflect price increases.

Claims for hospital charges represent about 45 percent of premiums. Claims to pay for doctors and dentists charges run about 40 percent of premiums and administrative costs ran about 11.5 percent in 1987. During a normal year, profits are expected to run about 2 and 3 percent. The 11.5 percent in administrative costs include such items as taxes and services performed for customers -- services such as managed care and utilization reviews, all of which attempt to help hold costs down.

State legislatures continue to mandate certain benefits in all insurance policies. There are currently a total of 735 state mandated benefits, more than double the number in effect in 1978. In a study by HIAA, Maryland's mandated benefits, which are comparable to Connecticut's, were found to increase the cost of individual coverage by 12 percent and family coverage by 17 percent.

All of these increases must be reflected in the insurance premiums insurance companies charge their customers. Commercial insurance companies from 1984 through 1988 continued to pay out more in claim dollars than they collected in premiums. During the mid-1980's, premium increases were between 6 and 8 percent annually, but as we reach the end of the 1980's, increases are in the double digits. However, insurers have not been alone in experiencing rapid claim cost increases. Employers and unions who have self insured have experienced similar increases in the cost of their benefit packages. As insurance premiums increase, individuals and businesses who are not purchasing medical insurance coverage also increase.

The insurance industry is greatly concerned about those 35 to 37 million Americans who do not enjoy the protection of health insurance. Over the last two years, the industry has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. Our companies are committed to working with government to implement effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of health insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured population; this heterogeneity requires a combination of private and public solutions.

Roughly three in ten of the uninsured are poor (with family income below 100% of the federal poverty level); three in ten are low income (between 100% and 200% of the poverty level); and four in ten are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make formulating any strategy for a public/private solution difficult. As such we see the need to address the special needs of the various subpopulations within the 37 million uninsured with a simultaneous multi-pronged approach.

The Health Insurance Association of America has advanced the following plan to address this issue.

1) The Medicaid program should be expanded in accordance with the following recommendations.

A. Expansion of Basic Medicaid Coverage

Ultimately we would like to see all Americans with incomes below the federal poverty level (and with limited assets) eligible for Medicaid, regardless of family structure, age or disability status. Accomplishing this would require severing the linkage between Medicaid eligibility and cash assistance.

If available funds do not permit full coverage up to the poverty level, HIAA believes priority should be given first to younger children, next to older children and finally to other populations. Priority should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to federal health care financing programs other than Medicaid (i.e., Medicare). This priority also reflects the critical need that children and pregnant women have for preventive services.

B. Limited Medicaid Buy-In

Individuals and families with incomes above poverty but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care through their state's Medicaid program.

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection.

C. Spend-down

Persons not otherwise eligible for Medicaid due to higher income should become eligible for full Medicaid coverage once out-of-pocket medical expenses reduce their remaining income to the federal poverty level.

Some coverage of last resort is needed to cover inpatient care and other large out-of-pocket expenses for the near-poor who cannot afford to purchase private insurance on their own and whose employers do not offer it or offer only very limited coverage.

D. "Buy-Out"

HIAA also recommends that Medicaid eligibles who are working be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs should be given the option of paying (and receiving federal matching funds for) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage.

Under our proposal, states would have the option of "buying out" two groups. First, more working people will qualify for Medicaid as the income level is raised to the poverty level for more persons and categorical restrictions are removed.

Second, current public policy supports the concept of encouraging low-income persons to work by easing the transition from public support to self support.

For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

2) Insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans so that insurers can design less expensive benefit packages for small businesses.

Once legislators start down the road of mandating benefits, it seems impossible for them to stop adding new ones. Our experience in the states has proved that, where state legislatures have enacted over 700 mandatory benefit laws, starting with mental health benefits and alcohol and drug abuse treatment and ending with everything from acupuncture and pastoral counseling to in vitro fertilization and wigs. Ironically, while these mandates do not apply to the vast majority of large employer and union plans (which are self insured) they do apply to most small employers who simply cannot afford them. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of state service and provider mandates.

3) Coverage must be made available to all Americans who are able to afford private coverage. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable employer group and uninsurable individuals.

To ensure access to affordable group coverage for all employees, a nonprofit organization should be established in each state to reinsure high cost employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among health insurance competitors.

Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals should also be supported. Such pools have already been enacted in 17 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity.

4) Small businesses should be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction, against their income tax liability, for their health insurance protection as long as they provide equal coverage to their employees. The 25 percent deduction which expires this year under current law, should be extended and increased.

Our proposals are designed to meet the needs of a heterogeneous uninsured population. We believe that they should be given an opportunity to work before government turns to unnecessarily onerous mandates. The HIAA four-point plan provides a blueprint for a truly comprehensive approach to solving the problem of the uninsured. The plan stresses the sharing of responsibility between government and the private sector. It calls on government to assist those who cannot be expected to pay for coverage on their own. We in turn will ensure that for everyone who can afford private coverage it will be available.

Thank you.

Mr. MORRISON. Thank you very much. Next, we will hear from Mr. Holdt.

STATEMENT OF RICHARD HOLDT, VICE PRESIDENT OF MARKETING, BLUE CROSS/BLUE SHIELD OF CONNECTICUT, NORTH HAVEN, CT

Mr. HOLDT. Thank you. My name is Richard Holdt, and I think I can help this morning with comments that represent thoughts from Blue Cross and Blue Shield, as well as from my position with the state's Blue ribbon Commission on the Uninsured, and the National Blue Cross and Blue Shield Task Force on the Uninsured.

There are several segments of the problem that I would like to address. Preliminary materials have been distributed; I will try to paraphrase those to keep this to a minimum as far as the amount of time goes.

First of all, regarding the rising health care costs, which is indeed a problem. The problem in Connecticut is unfortunately worse than it is elsewhere. Hospital cost increases nationally have been in the 20%'s in the last 3 years on an aggregate basis, whereas in Connecticut, they have been almost 60 percent.

Similarly, at the same time, our rank for health care costs nationally has jumped from number 13 to number 5 nationally; Connecticut is a very, very high cost area for hospital care. The uncompensated care portion of hospital cost has doubled in the last 3 years, going from 7 to 14 percent as represented by the Connecticut Hospital Association in this state. It is very much a problem in our state, and is a complex one at that.

It is also exacerbated, if you will, by the level of utilization of services. Physician services in the last 3-year period have increased over 22 percent. And the problem with this increase in cost and the increase in utilization of services, is it performs as a multiplier, if you will. The utilization multiplies and it compounds the effect of the health care cost. We find ourselves in a worse than average place regarding this dilemma.

Obviously, this has an effect on our premiums. As a major carrier in the state where increases were rather average a few years ago, they are in the 20%s and the 30%s now. The percentage of the increase is, obviously, causing quite an outcry in this state, and it faces all the carriers. Business has clearly had enough and is seeking alternative ways to still cover their employees and gain control over these costs. We have a number of active programs that we have initiated to attack this problem and are continuing on these in the new year.

Regarding children and families in Connecticut, we historically encourage programs that cover children and families. And all of our new product designs reference pre-natal care, and reference office care and office visits for those early visits in life as standard benefits.

Legislatively, two issues have come up to attack this problem. One is the Health Reinsurance Association, which has been established about 10 years ago to allow that pool of uninsurable to have a place where they can get insurance.

Unfortunately, while it has provided that avenue, it has become very, very expensive. The premiums for that segment have become almost too expensive for anyone to afford it, and the population that is able to afford it, has declined significantly over the years.

At the same time, those carriers participating, which is all major carriers in the Connecticut area, are losing millions of dollars a year. We think there is some tuning that is necessary to make this more of a viable alternative.

The second initiative regarding access to coverage for families and children deals with a mandate that was passed this past year to provide early childhood benefits in all health insurance policies. I have already stated that we very much favor this as an initiative, and indeed include it in all of our new products.

What the mandated law did was put it into all the old products, as well as all the new products. This could have an inhibiting factor on getting people over toward broader new products that deal more with managed care, and deal more with controlling the cost of care in the 80s as opposed to how they were initially developed a decade or more ago.

Regarding Connecticut's efforts in the uninsured, indeed there is a Blue Ribbon Commission that is dealing with the uninsured issue. There is a consultant that is working on the program, and we hope to have a proposal to put forth to our state legislature by early next year. March is the target date. We are in preliminary stages with this, however, there are a couple of themes that seem to be emerging. Some of them may very well be of concern to others that are here today, because they are somewhat different than the positions that have been expressed so far.

One of the thoughts that has been expressed by many of the people in this group, is that there probably is not any one solution. The problem is multi-dimensional; and, therefore, multiple solutions are necessary.

There are many that have spoken in favor of a focused approach, and an incremental approach as the way to attack this as opposed to a more universal approach.

And indeed there is a willingness and a call for every party that is participating in this system to come to the table with something to offer to help.

The carriers have to get involved and have to be willing to offer more affordable coverage.

The welfare programs should consider ways to loosen up medical benefit eligibility to open that up to a more broader section of our population.

Providers have to again look at their social responsibility and how they act about participating in programs such as Medicaid and Medicare, as well as how they can help in covering and to working with all segments of our population.

And indeed everyone has to be willing to pay their fair share. And that has to be apportioned in some way that indeed is a fair share across our spectrum.

There are a lot of initiatives similar to the state initiatives that are going on throughout the country. The Robert Wood Johnson Foundation, for example, has 5 or 6 demonstration products dealing with the uninsured and dealing with access for that segment.

And what we seek is that the information regarding all these programs be gathered and shared and transplanted from one area of the country to another so that we can use the successes that are uncovered in this operation.

And then the last item I wanted to discuss was a little bit on the Blue Cross and Blue Shield perspective on this entire issue. Clearly we feel that no one party is responsible, and similarly that no one party can resolve all these issues. There are collaborative efforts that are needed, and that is what we would hope would emerge from both local, as well as national, initiatives.

There are some major initiatives that are going on and we want to capture that value. Businesses clearly in the state of Connecticut, as well as elsewhere, have had enough. They do not want any more health care costs and health care premiums.

The incremental effect of mandated benefits, while they seem to be ideal when they are considered one by one, is indeed becoming a barrier to cost effective coverage.

And the effect of being uninsured is becoming very much a public issue, if you will, as the stories from those less fortunate than ourselves are becoming more and more evident.

We do not feel that a massive universal program is necessary at this time. While the problem is certainly a massive one, we think that there are enough efforts that are going on in various parts of the country that we can bring some of these efforts to bear and solve this incrementally as opposed to, in one mass program.

One of the things we would encourage is tax incentives for small employers to encourage them and attack that segment of small employers that do not offer coverage to try and get those industries that do not offer coverage to offer coverage.

The expansion of Medicaid eligibility so that those near the poverty level can get medical care easier.

The elimination of mandated benefits, perhaps even only in those programs that might attract more and take people out of the uninsured roles.

Fine tuning of state risk pools to better spread the cost of these and still make them available to people on an affordable basis.

And then finally, competition among carriers to offer basic benefit programs. Obviously, Connecticut is the insurance capital of the nation, and the carriers in this state have no problem going head to head to compete. And what we have to do is set up mechanisms that can allow that to happen as potential solutions, as incremental solutions to this problem.

Obviously, the Medicare Catastrophic is an example, and a very recent example, that is not a good situation from anybody's perspective. Out concern is that more and broader solutions can lead to the same things in other segments of our seeking this problem solution.

Thank you.

[Prepared statement of Richard Holdt follows:]

Prepared Statement of Richard S. Holdt, Vice President of Marketing on Behalf of Blue Cross/Blue Shield of Connecticut, Inc., North Haven, CT

My name is Richard S. Holdt. I am speaking today on behalf of Blue Cross & Blue Shield of Connecticut, our State's largest health insurer with programs that cover almost half of our State's population.

I am the Vice President of Marketing for Blue Cross & Blue Shield of Connecticut, Inc. In addition, I am a member of the Governor's Blue Ribbon Commission on State Health Insurance and a member of the Blue Cross and Blue Shield Association's Task Force on the Uninsured.

I will focus my comments today on four primary areas including:

1) Rising Health Care Costs - the Connecticut situation;
2) Historical Connecticut efforts to provide coverage for families and children;
3) Recent Connecticut efforts regarding the uninsured;
4) The Blue Cross & Blue Shield of Connecticut perspective.

Rising Health Care Costs

The national trends in health care costs are indicative of a crisis situation. Data regarding the ever increasing percentage of the Gross National Product are widely communicated and understood. Unfortunately the situation in Connecticut is worse than the national average. This is due primarily to recent hospital cost increases and recent increases in utilization trends.

Regarding hospital costs, Connecticut has just repealed a DRG hospital reimbursement system. The results, however, linger on. During the most recent three years when national hospital costs increased approximately 24% Connecticut's increased over 58%. Our ranking among states with the highest hospital costs jumped from 13th to 5th nationally during this period . . . a dubious honor to say the least. During this same period the percentage of uncompensated care as related to gross patient revenues increased from under 7% to over 14% per the Connecticut Hospital Association. It is still not clear how our new legislation and regulation will affect these disturbing trends.

Regarding physician and other professional services; the charges and utilization of these services also increased at alarming rates. For example . . . the number of Medical/Surgical services per 1,000 members increased over 22% in the last three years. And mathematically, the increases in charges and the increases in utilization have a multiplier or compounding effect that makes the situation even worse.

All of these factors have an effect on our premium rates. While 1986 and 1987 premium increases for groups of 50 or more contracts averaged 8% and 12.5% respectively, our 1988 and 1989 averages were 23% and 36%. Such rate increases clearly have a negative effect on the availability of affordable coverage for Connecticut citizens. Similarly our corporate loss of over $50 million last year clearly had a negative effect on our reserve levels and our ability to offer more affordable programs.

We are actively pursuing communication, product design, provider negotiations and benefit management initiatives to moderate these trends.

Historical Connecticut Efforts to Provide Coverage for Families and Children

Blue Cross & Blue Shield has consistently encouraged benefit programs that include meaningful coverage for families and children. All of our newer products automatically include the pre-natal, early childhood and managed care features necessary to assure availability and access to necessary care.

Legislatively there have been two initiatives that extend the availability.

1. Approximately 10 years ago a Health Reinsurance Association was established by state statute to assure access to comprehensive medical coverage for all. Unfortunately high utilization has led to premium increases, membership declines, and the emergence of a pool made up primarily of uninsurables. While over 50,000 contracts were originally covered through identical Blue Cross & Blue Shield and Health Reinsurance Association Products, today only 10,000 contracts remain. Even with the premium increases, Blue Cross & Blue Shield and commercial carriers lost millions of dollars annually without benefit of premium tax credits.

2. During 1989 the State legislature passed a bill mandating early childhood benefits in all health insurance policies. While this seemed like a laudable proposal the bottom line effect was an additional 5+% increase in many policies. As mentioned earlier we are, as a matter of policy, including such benefits in our new product offerings. We are concerned that mandating it for all policies may adversely affect the expansion of more cost effective programs.

Recent Connecticut Efforts Regarding the Uninsured

The number of persons without health insurance coverage is alarming nationally and in Connecticut. Last year our legislature established a Governor's Blue Ribbon Commission on State Health Insurance to seek solutions to this multifaceted problem. This group includes representatives from consumers, providers, business, carriers, special needs populations and government. They are working toward a proposal that can be released by March of 1990.

While deliberations are still quite preliminary, there are several themes that have emerged.

1. The problem is multi-dimensional and segmented. There probably is not one solution that can solve it all effectively.

2. Given budget constraints and economic problems, a focused, incremental approach may be appropriate.

3. There is a need for every party to come to the table with ways they can help . . .
   carriers must determine ways to make basic benefit coverage affordable;
   welfare programs should consider ways to loosen medical benefit eligibility;
   providers must consider their social responsibilities to the uninsured/underinsured;
   everyone must be willing to pay their fair share, etc.

Similar commissions and demonstration projects are operating throughout the nation. It is critical that we monitor results carefully and transplant concepts and programs that are successful.

The Blue Cross & Blue Shield of Connecticut Perspective

We believe that no one party is responsible for the current problems of rising health care costs and the uninsured and that no one party can solve them. We call for collaborative efforts that seek specific solutions for specific segments of the problem.

There are major initiatives already going on across our nation. Businesses have had enough of major health insurance increases. The incremental effect of mandated benefits is being recognized and increasing pressure is mounting to reducing this barrier to affordable insurance. The devastating effect of being uninsured is garnering widespread attention. We feel that these concerns and related initiatives must have time to come to closure. We do not feel that a massive Uninsured Health Insurance system is appropriate at this time. We call instead for improvements in our current pluralistic system of health care financing. We encourage ways to carry these initiatives forward including:

1. Tax incentives for small employers who offer health benefits to employees;

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2. Expansion of Medicaid eligibility for Medical Care;
3. Elimination or reduction of mandated benefits;
4. Fine tuning of state risk pools to better spread the cost and increase the affordability of benefits;
5. Competition among carriers to offer basic benefit programs.

The Medicare Catastrophic Care issue has made it all too evident how difficult it is to deal with health care systems problems in a broad way. We encourage a local challenge to find solutions, to execute solutions, and to share positive results about solutions as a better path to follow.

Mr. MORRISON. Thank you.
Ms. Spegele.

STATEMENT OF JANET SPEGELE, VICE PRESIDENT, LEGAL DEPARTMENT, CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION, HARTFORD, CT

Ms. SPEGELE. My name is Janet Spegele, and I am Vice-President of the Connecticut Business and Industry Association, CBIA. The association represents approximately 6,700 firms in this site, employing well over 700,000 men and woman in this state. Though many of our members are large employers, certainly the vast majorities of those 6,700 companies are small employers employing fewer than 100 employees.

My perspective today is the one that I have been asked to speak on, which is the effect of rising health care costs on Connecticut employers, and on Connecticut employer's ability to provide health insurance for their employees.

Health care costs are indeed rising. I think we have heard about it, but I think it is interesting to look at it from the perspective of the employer who is now paying a significant portion of those costs. Every year CBIA conducts a survey of its membership to identify some of the problems that are of greatest concern to these members. And this years survey has some good news in that, as in many years in the past, we have recorded that a substantial majority of our members do provide health insurance, do offer it as a benefit to employees, and it is somewhere around the 95 percent range.

I think when we look at the statistics on the number of uninsured in this state, many of those statistics are based on extrapolations from national figures. When we look at our membership, we find that projections which the number of uninsured are somewhat less than some of these extrapolations from national figures. Maybe because this is an insurance capital, and insurances are readily available here. But certainly among our membership, there is a very, very strong showing or provision of health insurance.

That is the good news. The bad news, of course, is what we have been hearing on these panels all along, that health insurance costs are rising at startling rates. From the survey that we conduct every year, ⅔ of our employers report that the cost of insurance has risen more than 20 percent; ⅓ report that it has risen more than 30 percent; and for the first time, we have got a significant portion, I think 10 percent is a significant portion, reporting that their health insurance is increasing over 50 percent. A very large chunk, and a very large cost of doing business.

More important than the rate of increase is the proportion that employers are being asked to spend on health insurance. And though we do not have any state wide statistics on this, one of our major Connecticut manufacturers did do an in-house study of this over the last decade and found that whereas 10 years ago employee health insurance costs represented 18 percent, of the average employee wage paid to that company's employee, today those health insurance costs have risen to 30 percent of the average hourly wage.

What that means is that it is really an add-on to every employee hired. On top of the wages paid, on top of worker's compensation, on top of unemployment compensation taxes, on top of a whole series of other costs we have a 30 percent add-on in health insurance costs that must be paid. That has to have a chilling effect, I think, on any decision made in terms of expanding the work force. And it has a compelling—it is a compelling factor in terms of thinking about reducing the work force.

With costs of this magnitude, it is no surprise that our survey again shows that the number one concern, the number one cost concern of businesses in this state on this survey, is the rising cost of health care. Faced with escalating costs, employers have been compelled to find ways of slowing the increases, or jeopardize their ability to compete nationally and internationally.

And I think I would like to emphasize that point because earlier Congressman Morrison made the point that these costs are really not absorbed by businesses, they are passed on. But I think as we look at the nature of the economy, it is no longer one in which prices reflect, or can continue to rise unless productivity is decreased. That many, many of our Connecticut employers are competing not only nationally, but they are competing in international markets where the cost of producing a product or a service is considerably lower.

So, to the extent that productivity can be increased, some of these increased costs can be absorbed. To the extent that they cannot be increased, they must be absorbed by the employer and cannot be passed on in prices because that would jeopardize the ability to compete.

Employers are responding to the high cost of health care in a number of ways. As an organization, CBIA has been directly involved in examining increases in hospital charges. We have learned already that hospital charges make up a significant, probably the largest single portion of the insurance claim dollar paid out.

And we too are concerned with the issue of looking at the difference between perhaps the price charged for a service and some ways of getting to more efficiently and more cost effectively providing that service, and really questioning whether the price charged is reflective of the cost of that service and try to narrow the difference between examining whether there is a way of narrowing the difference between cost and price.

On an individual level, employers are instituting series, with the help of insurance companies, instituting a series and a variety of ways of trying to more efficiently deliver health care, doing it at a more cost effectively in a more cost effective way through utilization of HMOs or through flexible benefit plans, or through utilization review. Any number of managed care elements are being introduced to try to make better use of what is available.

One of the more prevalent ways, unfortunately, over the last decade of trying to save costs for employers is to be asking employees to take a greater portion of the cost of health insurance. Whereas, a number of years ago, in the '40s when health insurance was for the first time offered as an employee benefit, the employers absorbed that cost almost universally.

As time passes, the cost of becoming so high has meant that it is compelled them to ask employees to absorb some of these costs. And our survey shows that more than 40 percent of our employers are now examining that as an option, either increasing, or for the first time asking employees to shoulder some of the cost of health insurance that is provided through the work place.

On the one hand, we find that when employees have a greater stake in paying for health care through their health insurance, they are more likely to be more efficient users of this care. And to the extent that we can more efficient utilization of health care in this state, or in this country, we are going to have an effect and an impact on stabilizing medical costs.

On the other hand, employees found, or asked, to contribute to health care costs or to health insurance, sometimes find themselves unable to do that. And to that extent, the shift to asking employees to pay for health insurance or to contribute to those costs is actually contributing to a larger pool of uninsured.

But just as individuals are finding that they cannot afford to shoulder the cost of health care, we find that more and more employers are finding that they cannot shoulder the cost of health care either. And as an organization, we provide health insurance, or serve as a conduit of providing health insurance to small employers in this state.

On a yearly basis, as those health insurance premiums rise to absorb some of the cost of rising health costs, there are—there is a statistic called the non-renewers. Those companies, and in this case, all small employers, find that they cannot renew. Cannot renew because the cost of their—the increase in their premiums has meant that it has simply become a prohibited expense, so that we are finding that the high cost of insurance is creating real barriers to coverage, and deterring, I think, the expansion of employee health insurance in the private sector.

At the same time that employers are finding it harder to provide health insurance, we look at the narrow eligibility for Federal and state health insurance programs, and we find that there are a significant number of individuals who are at or near poverty who are left outside of the Federal and state entitlement programs.

Kenneth Thorpe, in his testimony, already alluded to the statistics that if Medicaid were expanded to include individuals at 200 percent at the poverty level, the expansion would reduce the number of uninsured individuals by approximately ⅔.

In addition to these narrow eligibility standards, there is also the whole issue of sufficiency of funding. Medicare and Medicaid reimbursement are not keeping pace with the cost of health insurance nor health care. And to cover these short falls, hospitals and doctors alike are passing on their loss that they are suffering . private patients, and, therefore, to employer funded health insurance. Employers are, therefore, not only paying the cost of medical care for their employees and their employee dependents, but they are funding the deficits created by inadequate Medicare and Medicaid funding.

I have also been asked to speak on the much larger topic of how to expand access to health care in the United States, especially for families and children. And I think I have just referred to the first

step that I think has to be taken, which is for the Federal and state government to live up to their responsibilities and adequately fund Medicaid and Medicare programs. And that adequacy means sufficient reimbursements to cover the cost of programs that are already available, but also, as I mentioned before, expanding eligibility to cover those who are at or near the poverty level.

Adequate government funding would eliminate or significantly reduce the private sector subsidy of government shortfails, and make private insurance more affordable, if not totally affordable for many more employers and employees.

Another step has already been alluded to, and that is the examination of health insurance mandates, which are primarily a state function. Examining them, not only in terms of their impact on cost, but in terms of their impact on health status. More does not mean better in terms of the quality of care, but it certainly does mean a great deal more in the price of that care.

Some statistics have already been alluded to by the previous speakers. I do not think there is any single answer to how to best expand that access to health care coverage. And there is no question that it is a problem. But from an employer perspective, I think the first step, and the best step, is to try to work on bringing down the cost of care, and bringing down the cost of insurance so that more people can afford it.

Thank you.

[Prepared statement of Janet Spegele follows:]

PREPARED STATEMENT OF JANET SPEGELE, VICE PRESIDENT OF THE LEGAL DEPARTMENT, CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION, HARTFORD, CT

My name is Janet Spegele. I am a vice president for the Connecticut Business and Industry Association (CBIA). CBIA represents approximately 6,700 firms which employ over 700,000 women and men in Connecticut. Our membership includes firms of all sizes and types; however, the vast majority are small businesses with fewer than 100 employees.

I've been asked to speak on the effect of rising health care costs on Connecticut employers and on their ability to provide health insurance for their employees.

Health-care costs are indeed rising. Every year, CBIA condusts a survey of its membership to identify areas of special concern to employers. In this year's survey - as in our previous surveys - the overwhelming majority of employers report that they provide health insurance coverage for employees (95 percent). But the cost of this coverage has increased at startling rates over last year:

- Two-thirds of employees report that the cost of health insurance rose more than 20 percent;
- One-third report increases of more than 30 percent;
- 10 percent report increases of more than 50 percent!

But even more significant than the rate of increase, is the proportion of dollars spent on employee health insurance coverage. One major Connecticut manufacturer has done an analysis of health-insurance spending in relation to employee wages over the last 10 years. He found that whereas 10 years ago employee health insurance costs represented 18 percent of the average hourly wage paid to the company's employees, today this company's health insurance costs represent 30 percent of the average hourly wage.

This 30 percent add-on to wages must be factored into any decision concerning whether or not to expand the workforce and whether or not to reduce the workforce.

With costs of this magnitude, it's no surprise to find from CBIA's membership survey that employee health insurance costs are the number-one cost concern for Connecticut businesses, outpacing even business taxes. Faced with these escalating costs employees have been compelled to find ways to slow the increases or jeopordize their ability to compete nationally and internationally.

And employers are responding in a number of ways: They're instituting managed care elements into their insurance plans for more efficient utilization of services; they're changing health-care plan designs, such as HMOs and flexible benefit plans; and they're asking employees to share the costs of coverage. (Over 40 percent of employees report having initiated

or increased employees' contributions for health insurance coverage over the last year.)

Sharing the costs can slow the rate of increase in employers' costs and increase employees costs. On the one hand employees who have a stake in paying for their health care are likely to be more efficient users of this care. And in the long run, more efficient utilization could help stabilize the costs of medical care.

On the other hand, employees who are asked to share in the costs of their medical insurance may choose to do without insurance rather than contribute. I can't help but wonder how many among the numbers of the medically uninsured who are employed or dependents of employed have been offered insurance on a cost-sharing basis through an employer but have chosen not to contribute to the costs.

Of course, the significant cost of employee health insurance has also meant that some employers simply can't afford to provide it at all - just as some individuals can't afford the costs.

The high cost of insurance has created a barrier to coverage, deterring the expansion of employee health insurance coverage in the private sector.

At the same time, the narrow eligibility criteria for federal and state health insurance programs has left a significant portion of individuals who are at or near the poverty level outside the Medicaid system. It has been estimated that if Medicaid were expanded to include individuals at 200 percent of the poverty level, the expansion would reduce the number of uninsured individuals by two-thirds.

In addition, the federal and state funding that is available is not keeping pace with rising health-care costs. Medicare and Medicaid reimbursements fall short of the full cost of medical care. To cover the shortfalls, hospitals and doctors are passing on the loss to private patients and therefore to employer-funded health insurance.

Thus, employers are not only paying the costs of medical care for their employees and employee dependents, but they are funding the deficits created by inadequate Medicare and Medicaid reimbursements.

In discussing the problem in this country of the medically uninsured, it is often observed that the United States is unique among Western nations in its failure to have a national health insurance program or national health service that makes health care available to all its citizens. But another aspect of this uniqueness, is that the U.S. stands alone in using employers as the primary funding source of medical care.

This leads me to the final topic I've been asked to speak on: How to expand access to health care in the U.S., especially for families and children.

I've already referred to the first step that must be taken in improving access. Both federal and state governments must live up to their repsonsibilities and adequately fund the Medicare and Medicaid programs. Adequate funding means providing reimbursements to cover the costs of care for those currently eligible for these programs and expanding eligibility to cover those who are at or near the poverty level (e.g. at 200 percent of the poverty level).

Adequate government funding would eliminate or significantly reduce the private-sector subsidy of government shortfalls and make private insurance more affordable for employers and employees.

But additional steps must be taken to make private health insurance more affordable: The cost of health insurance mandates must be thoroughly examined to determine their impact on cost and their impact on health status. Requiring that every group health insurance policy provide cadillac coverage only guarantees that the insurance will bear a cadillac price tag and place the product out of reach for many employers and individuals.

There is no single answer to the complex problem of how best to expand access to health-care coverage. But taking steps to make coverage more affordable will go a along way to making it more available.

Thank you.

Mr. MORRISON. Thank you Ms. Spegele. You quoted me a little bit out of context, and I think we ought to clarify it. You said that I had said that all the costs were passed on. I said that corporations do not have an independent way of paying for things. They pass on part of the cost to the Federal government through tax deductions. They pass some portion of the cost on in their prices, and some portion back to their stockholders in terms of lost profits. And that was my point. Not the point that you seem to suggest that I made.

Ms. SPEGELE. Forgive me.

Mr. MORRISON. I just think it ought to be clear. I also find that everybody seems to say about how complicated this problem is. However, one does have to say that it is extraordinary that while every other industrialized society in the world has answered this question of complication by taking a universal approach, everyone on this panel seems to be very reluctant to embrace that kind of answer.

Please explain to me why it is that the United States is so unique among the OECD countries that this one somewhat simplifying and unifying principle which seems to apply in every other society does not apply.

And the question I would like each of you to answer to get at that question is, what is your view of the relationship of access to health care to the role of being a member of this society? Is health care something in the nature of a right that members of the society should expect to have? Or is it, like cars and other commodities with which if you cannot afford one, well, that is the price of the market place? We obviously have both kinds of things in this society. Some of which we distribute as a matter of right, like an education. We say that every child should have a right to a certain basic education regardless of his or her income level. On the other hand we say that many commodities that are market place commodities, access to which is purely a function of your market place power—how many dollars you have to bid with.

I think that this is a fundamental value choice that the country is faced with, and I wonder what the position of your organizations is on this question. Which is it?

Ms. SPEGELE. I do not think that our organization has taken a position. I think our country probably has taken a position that health care has become over time a matter of right. None of the segments of the population have been willing, and I do not think should be willing, to deny health care where it is needed. And I think there is a general, a societal view that health care should be available to all those who need it.

It is a question of how to achieve that. And where we have models available, and I am not speaking from a position of expertise, I am speaking now as sort of an observer of the scene, where we have models available, and kind of perhaps one that has been referred to earlier, the statistics would show that there is less money per capita than yet a greater availability.

And one of the things I think in looking at, and trying to make health care more universally available through some sort of a national plan, is that it would not be like Canada. It would not be more persons getting it for less than we are now paying, with more

persons getting it for a great deal more than we are now paying for it because I think there are a series of expectations in this country that are very different than those that exist in Canada or in Great Britain.

And we have become used to, those of us that have that care, to the maximum that is absolutely available. We want it now. And that is not the Canadian or British expectation of care. There are those who are crossing the border from Canada so that they can get what they want now by going to American hospitals and paying for it.

But when we are looking at the Canadian or British model, I think it is important to look at the difference in the set of expectations that Americans have, or North Americans in the United States have about health care, versus those in some other countries that now have additional health care available.

That is not to say it will never work. It is just to say that it is not so easy to place that model onto a U.S. population and expect it to work quite the same way.

Mr. MORRISON. Well, let me understand what you are saying. That is a very interesting comment. You argue that between the United States and Canada, which physically, geographically, and culturally is our closest relative among nations, that basically, we want a lot more and have much higher expectations of what we should be able to get and how quickly we should be able to get it, et cetera?

Ms. SPEGELE. I made that comment, not because I am an expert on it, but——

Mr. MORRISON. Well, we do have an expert here, and he will probably tell us what he thinks about that in the next panel. But I am more interested in whether that leads to the conclusion that there is no dollar level, no GNP percentage level, at which Americans would be more satisfied with a universal system than the one we have now where we keep the price down by keeping certain people out?

In other words, letting some people remain out of the system is how we keep it from going from 11 percent to 15 percent of the GNP. If you are right, in order to get universal, we just have to spend more.

But this does not get you away from the basic value question of whether we are going to save money by keeping people out or save money or not save money—by letting more people in?

Ms. SPEGELE. I do not think I answered the basic value question.

Mr. MORRISON. Well, let us give some other people a chance at the basic value question.

Mr. LEROY. Congressman, I think in this country that indeed we have reached the stage where, in fact, health care is looked at as a basic right. And I guess the question is, how is it provided? Is it provided through a wholly governmental mechanism, or is it provided through a combination of private and public mechanisms?

What gives us pause. I guess, in fact, of course, I have a—my companies I represent have a very large stake in how that is answered. We do provide health insurance to the vast majority of Americans through the private sector mechanism of it.

But the issue of finding a level so that all are covered is a real issue that Congress has to struggle with. I guess what gives us pause in a sense is how Congress has decided on how it has managed the Medicaid and Medicare program to some extent.

Both started out with the intent that all would want to provide coverage for various segments of the population that might not be covered by private sector insurance, Medicare for the elderly, some disabled Medicaid for the poor.

And what we have seen over time is a continued promise of benefits with a ratcheting down of a financial commitment to provide the coverage that was promised, with disastrous results for both hospitals, providers, private insurers, and employers because, in fact, we are paying the tax for, right now, that is a hidden tax, of the cost shift of the inadequate reimbursements that are going to cover these individuals who are supposedly promised coverage.

What is a concern when you talk about a general omnibus sort of solution is, what is the Federal government going to do? Promise again, and then start ratcheting away at the original promise? That is a concern.

As Jan said, I think that there are other issues involved when you start to talk about comparisons between——

Mr. MORRISON. Wait. We are way down the road beyond the basic question. I am very interested in your observations, and I want to come back to them. But let's try to focus them, rather than getting into a long discussion.

I want people to answer the question of whether you think that our society ought to treat access to health care as a right in society as opposed to something that depends on one's market power?

Mr. LEROY. That first question is an answer, yes. And there are different solutions as to how that is done.

Mr. MORRISON. Well, it frankly surprises me that the health insurance industry does not want to sell health insurance to the Federal government for everybody. It is kind of bizarre that your answer to the question leads to, "Let the government deal with some marginalized population and let us deal with what we view as a more profitable population."

Mr. LEROY. We are hit on the same issue of why are you not for an employer mandate? Does that not mean increased, if you have an employer mandate, does that not mean an increased market for your products? Our industry has looked at it and stepped back and said, that might be fine and dandy, but in short, what does that do to our economic system when you have small employers who are not going to end up economically viable because of the increased costs that we place upon them? We have tried to take a broader look, Congressman.

Mr. MORRISON. I understand that, but my point is this. As to employer mandates, it is very noble of you not to want to do more business because you consider its impact. It ought really to drive you to ask the question, why do we have employer based payment at all for health insurance? Does that make any sense when you find that as employers get smaller and less profitable, loading that particular cost on to them on a per capita basis does not necessarily come out with a good economic result?

What that ought to drive you to is the question, why we have this system of payment at all?

Mr. LEROY. I would disagree that our system of providing health insurance through the employer mechanism is not working. It has worked, and it should continue to work if certain actions are taken by the government to allow it to continue to work.

Mr. MORRISON. Well, you know, there is a lot of dissension among the Fortune 500 leadership. The CBIA's position today does not sound exactly like what I hear from the executives of major Fortune 500 companies about whether they think the employer-based health insurance system is working. Those who are exposed to international competition seem to particularly find that the American way of paying for health care is very damaging to their international competitiveness because their burden of paying for health is on a per capita basis rather than on the basis of their profits.

Mr. LEROY. I have to make one comment, and I will let you get on to try and get other answers from it. But the comparisons are not as clean cut as some would make it out to be. If one looked at Canada, for example, there is more going on. I mean, you know, the issue of statistics. But we began about I believe 15 years ago with the same percentage of GNP going toward our health care system What occurred from that period of time up until now is the fact that they have had much faster growth in Canada than we have had in our economy in the U.S.

If our economy had grown at the same percentage as Canada, our percentage of expenditures going to our health care system would be lower. So, you have to be a little careful in some of the comparisons that are being made.

Mr. MORRISON. I think we will get a chance with Professor Marmor to get into some of those questions down the road.

Mr. Holdt.

Mr. HOLDT. I would say that the goal is that health care is a right. However, because of limited capacity, dollar capacity, or provider capacity, then it becomes almost a commodity. So, the goal is a right, but because we do not have enough to have everything for everybody, which is indeed what we want here in America, it is becoming more of a commodity.

So, it becomes an issue of how you draw the boundary line. In the model that we have active in the United States today, and it is not right, it is a boundary line that is based on economics. The poor, more often than not, are the ones that fall out.

In the British system, the boundary line is sometimes based on age. They have also a limited capacity, but the most popular problem example is that if you are over 50 years old and you need dialysis, you just do not get it. Well, that is not good enough. That is not going to fly in New Haven or anywhere in America. People are going to say, hey, I want that.

The way we are doing it is not so right, but the way that some of universal programs are not necessarily right either.

Mr. MORRISON. What you are saying is that if we are going to limit the dollar amount spent in any way, at some level there is going to be rationing. Unless we are willing to spend an unlimited

amount of money, something is going to have to be the dividing line?

Mr. HOLDT. Yes.

Mr. MORRISON. But the question really is ought we to be striving to have the limitation, or that awful unspoken word, the rationing allocated on some non-economic basis having to do with the benefit of the particular health intervention or the relative choice between the needs of people involved, whether it is the youth or some other measure like that? Does Blue Cross have an opinion on this?

Mr. HOLDT. I do not know as an official spokesman, if you will.

Mr. MORRISON. I have some more questions but I want to give everybody a chance.

Mr. EVANS. Mr. Leroy, you say that perhaps one of the ways we can deal with this problem is through expanded Medicaid coverage. And one of the options being allowing individuals or families with incomes above poverty but below 150 percent of the Federal poverty level should be eligible to purchase, to buy in basically.

In addition, I would like to say that perhaps persons who are not otherwise eligible because of higher incomes, ought to be able to spend down. I think the problem we have is that most people that, first of all, are in that category that might be able to buy in simply are using the money for other purposes. What kind of amount of money would you see that they would have to spend to buy in?

And then, secondly, I guess, the other problem is effectively this kind of expansion says to people, we will help you, but you have to waste all the resources and assets that you have accumulated over the years, which in many cases, I know from my own experience with this group of middle and lower income people is not much. What we are saying is, basically you will get health care if you spend off what you have accumulated. Is that really realistic?

Mr. LEROY. Well, Representative Evans, on the issue of the buy in. I think that you can set those premium levels really anywhere you want to depending upon what sort of subsidy you want to provide. We have done some—we are doing some number crunching ourselves in regard to trying to look at prototype policies outside the Medicaid system to try and—if we were somehow to be allowed to preempt some of our current state mandates, what would the cost be if we had a very limited type policy to offer employers?

The same sort of analysis could go on looking at what sort of first dollar coverage can we provide somebody before they get into the Medicaid system? You can, depending upon the coverage, get the monthly premiums down significantly. But there is a trade off. Absolutely there is a trade off between the type of coverage to be offered versus how expensive you want it to be.

As I said, I think that is probably a less significant problem than indeed you point out on the spend down. That issue is a real one, and I think it is a balancing between how our society places the price of governmental services. You know, the issue arises in Medicaid with the nursing home issue, which I am sure you have heard. Should you force somebody to become impoverished basically before you allow them into the governmental system of financing?

I do not have the answer to that. It is something that I am sure you struggle with all the time in Congress trying to find the bal-

ance between individual responsibility versus where the government should step in.

Mr. EVANS. I just wonder, you know, in terms of people that are just above the poverty level, if they are going to have any real incentive to buy into——

Mr. LEROY. Well, it is interesting in that some of the survey data we have done, we have always been on the premise, and we probably have our middle class biases, that we bring to our work as well as anybody else. If I didn't have all of a sudden health coverage from my employer what would I want?

I would want catastrophic coverage. Okay. I could go out and pay for the initial visits in that sort of care. And I would want to be protected if I had to go in the hospital, and it's going to run up a bill of $50,000.

Many of the people at the near poor, that is not what they are interested in. They know in a sense they do not have a huge asset base.

What they are looking for is some limited first dollar type coverage so that when they want to go down to the local doc and try and get some sort of first look, they will not have to have the choice of spending $15 or $20, which ends up being a deterrent to going down and getting in that door, sometimes causing the problem to get that much worse because they do not get into the health care system until much later.

I think both in some of the prototype policies we are looking at and in Medicaid, they are trying to look at limited type first dollar coverage knowing that if somebody is near poor, then the government is going to step in if somebody really has something serious.

Mr. EVANS. All right. Janet, why do you say in your statement that you wonder about the numbers of employers who offer a cost sharing basis insurance to their employees? Why wonder? Why not just include that in your survey next year? Why not ask your members just how many of them are offering those kinds of programs, and how many of their employees are participating? Could you share that with us?

I suppose this survey is just completed for this calendar year or something. Perhaps next year, if you could include that, we would appreciate knowing that. It would give us more of a factual basis.

Ms. SPEGELE. That's a good thought. Thank you for the suggestion.

Mr. EVANS. Thank you.

Mr. MORRISON. One of the things that is most striking about the proposals, which I would sort of call the private sector and provider community responses to this problem, is the interest in expanding the scope of people covered by Medicaid. That is said in the same breath, or in the immediately following breath, as describing all the inadequacies of Medicaid—the extent to which it is underfunded, the extent to which none of the providers are satisfied with the reimbursement rates or the reimbursement procedures.

And it is striking to me that we have the private sector arguing that it ought to be maintained as the insurance vehicle for most of the population, but that the most vulnerable people in the population should be covered by what you have defined already as an in-

adequate and underfunded system. Why? I really do not understand this.

I mean, I would understand if the private sector came and said, "We have got a product here. The government ought to give vouchers to buy it." Or, I would understand it if you say, "Well, the truth is that we cannot get universal coverage without some governmentally operated universal insurance system." But why are you for this two track system—because that is what it is, and you already know that Medicaid patients do not have the same access as private patients? They do not have the same access to doctors, they have problems in primary care, and all of the hospitals say that they do not pay their way. Comments from each of you on that?

Mr. LEROY. I think there are a couple of issues involved. I think Medicaid is, I will not say collapsing, but is experiencing problems in attracting providers and being attracted to hospitals. Primarily because of their reimbursement level. I have not perceived the fact that there is, necessarily has to be a two tiered system of health care.

Mr. MORRISON. But you would agree that we have one now with respect to Medicaid versus everybody else. And maybe we can find some more tiers to put in. But we do not have equal treatment right now, right?

Mr. LEROY. Not in hospitals, and I would be interested from what Sister has to say. In hospitals, once somebody is in that door, and in fact in this state, any uncompensated care is shifted over overtly to our regulatory method into the rates of private paid patients.

I am not that familiar with primary care. I would have to think, Representative, that there are problems.

Mr. MORRISON. And people do not get admitted to a hospital unless it is the most dire of circumstances and they walk themselves through the door. We get admitted to hospitals through primary care physicians or others. So, there are lots of conditions that go untreated in hospitals because the people do not have the basic system that gets them in the door.

Mr. LEROY. I would, again, I think that for the individuals who are in need of governmental services, there is nothing to say that Medicaid cannot work to provide the right level of financing in attractive right providers. But that is not happening right now.

Mr. MORRISON. Would you try to answer the question, why it is that you want for one group of citizens a government system, and for another group of citizens a private system? What is it that makes that good social policy? Why should it not be the same for everybody? What is so special about that group of people that you want to consign them out of your business, which is really quite strange?

Usually people want to sell their product to the broadest population possible, yet you want some people not in your market place. That is a very strange position for the insurance industry to be in. I would understand somebody else making that kind of proposal.

I still really do not understand why we should think about some group of people the government should take care of, and some group of people that should have private insurance.

Mr. LEROY. Let me see if I can try and make a point. One is, I think in this country it goes back to the fact of our society in that the private sector is used as a mechanism to provide products, to provide services if, in fact, there is not some sort of, I guess in economic terms, market failure so it does not work.

And we would still say that for the vast majority of Americans, the private sector of mechanism is indeed working. Now, to get to the point of whether there could be something structured so, in fact, the near poor end up utilizing the private sector mechanism. I am sure there are methods to exploring that. And I am not the expert representative to talk about that.

But as far as basically taking, and correct me if I am wrong, the other step and saying everything should be funded through the governmental entity, I think that is something that goes to the fact that our country looks to the private sector to provide goods and services rather than the government.

Mr. MORRISON. Yes, I think that is the position you probably should be arguing. You should be trying to sell this stuff and arguing that you are in the best position to sell it. I am not sure I would agree, but it seems to me a very strange position that you want to segment the market in the way that you do.

I would like Blue Cross to respond.

Mr. HOLDT. I think what we are saying is to try to fix something that we know rather than throw the whole thing out the window and start over again because we have not had a lot of success in some broad based programs. I do not think we are saying to expand it underfunded. We are saying funded.

Mr. MORRISON. Where is the money to fund it? You all want to expand Medicaid. Do you know where the money is going to come from? We have a $100 billion plus deficit in Washington, and we seem to have a similar one in Connecticut on a per capita basis. Where is the money to come from here?

Mr. HOLDT. In the state it comes from those that are insured, and that the uncompensated care——

Mr. MORRISON. No. Well, let us leave the issue of uncompensated care because we could have a long debate about whether it worked, more or less, under the old rating system. Now we have a new system that the hospitals like and nobody else does—except the hospitals cannot get their rates set, so they do not like it either.

But are you saying that we should raise taxes to pay for higher Medicaid and Medicare in order to get this system working, is that the bottom line?

Sister VIRGINIE. May I comment?

Mr. MORRISON. Yes, Sister Anne.

Sister VIRGINIE. I think earlier this morning one of the presenters talked about the fact, if we do a little altering of the manner in which we do pay for some of the services that we have right now, and I think she was speaking largely of those who are in the lower economic situation, that if we did things more timely, more appropriately, and paid for them, we would be reducing the cost overall. And those excess dollars so to speak could be used to assist in funding those situations. I think it was Dr. Klerman, if I am not misquoting her, talked about that possibility. And I think we really have to look at that.

We are focusing a lot on the economics of it, and appropriately so in this setting. But the fact of the matter is that, as a nation, let alone a community like New Haven or the State of Connecticut, we are not openly talking a major public policy kind of situation. We are the providers and the insurers and the legislators. But there does not seem to be a forum in which those who are really being impacted on are really involved in that kind of a decision.

And so, I am probably going off on a tangent in that regard, but I think we have a very serious social public policy issue that we keep talking about in smaller firms outside of those that are impacted on it.

Now, I wish today, for example, there could be people from the business community here sharing in this. And they have talked to you in other settings.

Mr. MORRISON. Well, that is the CBIA's role today.

Sister VIRGINIE. But I mean, the employees that are being impacted by this.

Mr. MORRISON. I think it is important to note that we should say that we only have the government come in when there is a market failure. It seems to me that 37 million uninsured, 40 percent premium increases, and employers finding themselves with 30 percent employee fringe benefit costs to carry health insurance are all evidence of a failing system. They are not evidence of success.

So, I think we ought not talk about our current system as if it is a smashing success at the moment. Listening to the debate over the hospital reimbursement system in Connecticut last year would not lead one to believe that most of the participants in the current system think everything is fine.

Ms. SPEGELE. I would like to clarify the position in case I mischaracterized it. I do not mean to be categorically coming out as an organization in opposition to a national health system. Nor do I mean to categorically endorsing a private sector government joining—I think what I am really saying is that we do not have the answers. And that is where we are back to the complexity.

If there was a model out there that was working to everybody's satisfaction, you could look out and say that is something that some of us could be endorsing. But as I alluded to before, I do not know that the American public, the U.S.A. public is, despite some of the surveys, are really willing to buy what the Canadian model is because of its implications for less care than is the expectation of Americans.

And I think all I am really saying is, given what we know, the choices are not particularly appealing, and you work with what you—to say again what Mr. Holdt talked about, you work with what you have got.

If what you know you have got is a Medicaid system that is not working very well, you come up with suggestions that are going to try to improve that. It is not to say that it is the best system, and that there is not something out there, but I think all the position that I am going to say about CBIA is that we have not seen it.

And if one is going to be advocated that really is working could work, that may well open up possibilities for endorsement. But at the current time, I do not know that there is something.

Mr. MORRISON. Well, our next panel is intended to give us at least some glimpses of some alternatives. I just would hope that you will hear this and take it back to your respective organizations: We do have a historical experience with the difference between need-based access programs versus universal social insurance approaches in the contrast between AFDC and Social Security.

It is quite clear that Social Security, a universal social insurance program to provide basic retirement, disability, and death insurance, has been funded at the rate of inflation since 1972 with broad public support. AFDC, which is a targeted, means-based system, is funded now at about ⅔ its 1972 level in real dollars. That ought to be instructive to people about what really happens in terms of underfunding or adequate funding of government programs. Broad-based social insurance has broad-based social support, and woe to the politician who attacked social security. But any time you want to find a few bucks you do not have, just cut a few bucks out of the AFDC and everything will be fine. And that is your Medicaid problem.

In my humble opinion, we are going to have it until we get universal health insurance, whether we buy it from the insurance companies or whether we buy it from the government directly.

Thank you very much for your testimony.

Our third panel is Theodore R. Marmor, Ph.D., Professor of Public Policy and Management, the School of Organization and Management at Yale University; Steven Wolfson, M.D., Chairman of the Health Systems Planning Committee, New Haven County Medical Association; and Leonard S. Krassner, M.D., President of the Connecticut Chapter of the American Academy of Pediatrics with office in Wallingford, to be accompanied by Elsa Stone, M.D. who is the Vice-President and Chairperson, Committee on Health Financing in the Connecticut Chapter of the American Academy of Pediatrics.

I would like to thank all of you for joining us today. We look forward to your contributions to the hearing. Your written statements will be made part of the record in full, and we would ask you to summarize.

Obviously, you have been here listening to what has been going on for some or all of the morning. Not only should you feel free, but you should feel specifically requested, since your panel is specifically alternatives and responses, to pick up on the various testimony and questions and tell us how you would answer some of the questions yourselves.

Professor Marmor, we will start with you.

STATEMENT OF THEODORE R. MARMOR, PH.D., PROFESSOR OF PUBLIC POLICY AND MANAGEMENT, SCHOOL OF ORGANIZATION AND MANAGEMENT, YALE UNIVERSITY, NEW HAVEN, CT

Dr. MARMOR. Thank you for inviting me to come to speak to this panel. What you said in general about the preceding speakers especially applies to what I want to say today. What I would like to do is talk about the way medical care arrangements are structured in Canada, try to address some of the myths that were repeated by

the panel before you this morning, and try to suggest realistically what it is we can learn from them.

Canadians do not have an idealized or an ideal system. They just have a system on most measures which is better than ours. And it is very difficult to get clear about that in the light of the kinds of claims that are made about the differences between the Canadian and American population.

So, I mean to go point by point through the main assertions I want to make, and assume that I can back them up in response to your questions. I want to be careful not to go over in the first round.

I think the first thing to notice in thinking about Canadian circumstances to our north is really a point you made, Congressman Morrison. And, that is, of all the countries in the world, Canada is the most similar to ours. It is not identical to ours. Just nothing else is closer. So, if you are ever going to learn from any place, you are likely to be able to learn from there before other places.

That leads me to draw a sharp distinction, for example, between comments made about foreign systems like Britain's or Sweden's as opposed to Canada's. That is, there may be some things true of all the foreign systems. And that would be worth noting because if it is true of all of them, it is likely to be true of us too eventually. But I do not think it is helpful to selectively pick other countries for comparison because Canada is so similar.

What do I mean by so similar? Well, for one thing, the world of Canadian medical care up through the mid-1970s was really practically identical to that of the United States. Physician operating in the Canadian hospital in a city like Toronto would have faced the same technology, have faced the same arrangements that they would have faced if they were in Chicago. Likewise, Vancouver to Seattle. Manitoba to Minnesota.

And if you ask what are the journals that they read? What kind of technology did they have available? What were their citizens expecting in the way of medical care? How do they deal with their hospitals? Were the hospitals owned by the Province? No. They were private community hospitals rather like ours with lay boards of directors. How were doctors paid? They were paid fee-for-service the way our physicians are paid. Where did the money come from? Well, it used to come from private insurance of the Blue Cross/Blue Shield kind, and then it came from the government.

In other words, Canada came in the 1960s and 1970s to something that you might call "socialized health insurance". That is not the kind of something called "socialized medicine". That is point one.

Point two, although the two countries are not identical at levels of economic growth and wealth and urban rural circumstances, anybody who has spent any time in Canada knows two things.

First, its diversity. Geographically and socially it is comparable to that of the United States. The differences between Prince Edward Island and Ontario are as great as the differences between Maine and California.

Secondly, they would know that Canadian society has a considerable amount of decentralization, comparable to our states. That is, the province's do a great deal of the work of government in

Canada. There is no radical difference between the role of government overall, or the dispersion of the role of government.

So, for all those reasons, since the time that Canada turned to a program of universal hospital and medical insurance. (As I said in the testimony, they came to it in two stages -in the late 1950s the hospitals, in the late 1960s the medical). By this time they came to an overall system step by step, but nonetheless complete, we came to a situation between the United States and Canada where we had something like a natural experiment to conduct. So, from 1971 to 1989, we have been conducting a grand quasi-controlled experiment in the impact of different kinds of funding on relatively similar medical care systems. In their case, for everybody in the population, in our case, for most people in the population through fragmentary financing and for some not at all.

Now, let me just say a word or two about what the present circumstances are, and then say what I think about the results of this experiment we have been conducting, and then the bearing of it on us.

Where are Canadians now? What is the situation with respect to health insurance? At the moment every Canadian citizen is covered for all basic necessary hospital and medical care expenses without co-insurance or deductibles. This is done through 10 provincial plans in which the Federal government pays 40 percent of the amount in each province if the province administers a plan which is open to everybody, has no cost sharing at the point of use, covers all basic hospital and medical care, and is publicly administered.

Those four conditions produced and justify the Federal compensation, and as you can imagine, there is no province that refuses those terms. So, that is the result.

Think about it this way. Imagine 25 years ago a very comprehensive Blue Cross hospital plan combined with a very comprehensive Blue Shield plan that had no first dollar deductibles or co-insurance. Imagine both of those things put together and run by a single unit and given to every citizen in every state in the United States. That is what you would have.

Those are the present facts about Canada. They spend in this scheme about 8½ percent of GNP—that is, about 3 percentage points of GNP less than we do—on health care. There are no financial barriers to care. Everybody is covered at an expenditure which is about ¼ less of their national wealth.

I will turn to the statement about how they grow faster and therefore spend less at a later point. That is what they have been doing since 1972.

What are the results of this experiment that ought to concern us most of all? Well, the first result I have already mentioned: they have managed to introduce comprehensive benefits and universal care at a significantly lower cost.

Their funding scheme, while it came in with an expansion of eligibility, brought with it a reduction of their relative performance and expenditures to ours.

Look at figure 2 of my testimony, Hospital and MD Expenditure as Share of GNP. I think it is useful. A picture does tell the story more effectively. As you can see from the post-war period, Canada

and the United States spent about the same percentage of GNP on medical care. In fact, it is hard to tell which is Canada and which is the United States for those years.

Notice that after 1971 there is a sharp divergence in the proportion of expenditure going to medical care. And the sharp divergence has Canada spending less and giving the most, and the United States spending more and giving the less. I can go on and talk about that later how that is accomplished. I just wanted to establish the fact that it has been accomplished.

The next result of the experiment is that in order to have done that—to have expanded insurance coverage at the same time they reduced the rate of increase in the share of GNP going to medical care—Canada had to bargain very hard with the providers of care, and that they did.

The 3 percentage points of GNP that are different between Canada and the United States are accounted for in the following way.

About 1 percentage point of that, about $40 billion is accounted for by differences in administrative costs. Not costs of actually getting care. Not medical care. It is not the cost of getting to the medical care. It is the cost of moving the paper around within medical care. If you look at my figure 3, you will see that the gap in administrative costs is just staggering between the United States and Canada. It is the fastest growing difference between the two.

The gap has been growing ever since the late 1950s and since the 1980s is just staggering. In other words, one of the costs of the explosion in cost shifting and managed care is that we spend a lot more money on maneuvering the dollars around and marketing those dollars.

The previous panel really illustrated for you the complexity they wanted to introduce into this system in order to get a handle on it. It is precisely this complexity that produces those administrative expenses.

Marketing the care, getting second and third opinions of the care, having physicians call up nurses to check in order to do something, deciding whether one is in one category or another category, making sure that patients go from this hospital to that hospital, having doctors worry about the coverage in this plan as opposed to that plan, deal with the disputes about whether it was right that you did X rather than Y.

$40 billion, or so some estimate. If you say that as if you knew that was the amount, you are a fool and should not be paid attention to. But something on the order of that is agreed to. Nobody gets healthier as a result of those expenditures, that 1 percentage point of GNP.

Probably another percentage point of GNP has arisen in differences between the payments for physicians. Now, it is important to keep in mind that payments for physicians are the number of items times the price of the items.

Canada has restrained very sharply the prices of the items that medical care physicians provide. Very sharply. Since 1975 or thereabouts, the fees for medical care have been kept at or below the general rate of inflation. In other words, the fee schedules have

been falling in real terms during the last 15 years. It is important to know.

The reason I bring it up is that one of the prices, or one of the consequences, of the Canadian scheme is that they have had very bitter continuing struggles over what those fees ought to be. To the extent they have been successful in restraining fees, they would have to be successful so to speak in generating conflict. There is no way to have one without the other.

National expenditures for medical care equal the incomes of providers in the nation. That accounting identify is the key to social conflict in this area.

What we do in the United States is disburse the conflict among citizens—sick people, doctors, patients, among all the parties. What happens in Canada is that the single payer is in sharp conflict with the providers over what they are going to be paid.

Now, doctors in Canada have expanded the volume of services to some extent, partly to compensate for lower fees. But still the combination of both that expansion and the severe restraint has meant that the amount of money going to physicians in Canada versus the United States explains possibly a percentage point of GNP.

And the other percentage point of GNP has to do with the way they budget and pay for hospitals. Every year in Canada, the provincial minister of health and that staff negotiate with each hospital. And they tell each hospital roughly speaking what the budget is going to be for the next year.

Now, that budget is going to be increased each year typically by the amount of economic growth in the society. The reason that is the case is that the Federal grant is indexed to the GNP growth of Canada. That 40 percent comes, in other words, with a year-by-year increase.

The province is going to have a hard time explaining to its citizens why it is not going to let its hospitals grow by the extent to which their country grows. But any dollars above that are argued like mad because the consequence for the province of spending anything more than last year's budget, plus the growth of the economy, means that you either have to increase taxes, or you have to lower the budget of other public programs in the province.

The best organized restrainers of medical care expenditures in Canada are other government departments who know that for each dollar spent beyond the expected increase in the medical care sector will come out of their high.

I will try just very briefly to explain why this difference is. What meaning does it have for us? What are the familiar charges and counter charges about Canada? And I will try just to hit on those very briefly assuming that you want to press on more.

First, is it the case that Canadian expectations for medical care are so low that it is possible to squeeze their budgets to 3 percentage points of GNP below ours without having squealing from the Canadian population because they are so used to deferentially taking whatever is given to them?

I think there is not one shred of evidence to support this claim, which was made in the prior panel. I do not know where it comes from. I will just give you an anecdotal illustration of it.

A woman in Ontario six weeks ago tried to kill herself by swallowing a whole number of poisons in her house. She came to the realization of what the consequences were going to be and rushed to the hospital in very bad shape. This is a real hospital with a relatively inexperienced resident on duty at the time. And he knew well enough that this patient ought to be getting to a tertiary care hospital.

But he did not know, or he forgot what you should do in those circumstances. They have a code for getting a helicopter in a very short period of time to bring those patients to the proper hospital. Instead he started calling by telephone to the various hospitals. It took him about 12 or 13 tries before he found one that had a helicopter and had an operating room ready. The patient died.

The next day that case was on the front page of every Ontario paper. The Prime Minister of Ontario, David Peterson, had to go into Parliament to explain why emergency care was not available. The Minister of Health, Eleanor Kaplan had to further explain, having investigated the case. And the answer was that this physician was not in a position, as he should have been, to have gotten the emergency code, and he had never faced anything like that because for lesser emergencies there was a hospital 30 miles away that would have sent one right away.

My point about that is, if the expectations were so low, you would never have that kind of response. Canadians expectations are really quite comparable to ours. They can watch the same television movies. (In fact, there is worry about their pollution by our television). Their physicians are trained in comparable settings. The range of technology is there. It is just that it is used less.

So, there is the charge of lower expectations. There would have to be lower expectations not only about the kind of medical care you would get, but in what order you would get it, or how much you would have to wait for it. So, that is one point. I do not think there is a shred of evidence to support that.

Canadians are very sensitive to the quality of care that they receive. They turn out to be very pleased on average with their medical care. Medicare is the most popular single program in Canadian government. No Canadian government would dream of changing it.

And, indeed, when the Free Trade Act was presented, there was a period, a very short period of time, when it was thought that American businesses would complain about Canadian Medicare as an unfair trade advantage since those firms did not have to pay high health care prices.

And for a very short period of time, the presumption was that the Free Trade Act might force a change in Canadian medical care policy. There was a 15 point shift in the polls against the current government until Chief Justice Emmett Hall could get on television. He is the person who was the author of the Canadian Medicare Act of 1964. He got on television and assured that he had consulted with the Prime Minister and that nothing like that would happen. So, that is point one.

Point two. The lesson from Canada is that an enormous amount of the differences in our experience is explained not by differences in culture or attitudes toward medicine or what doctors and hospitals want to do, but it is explained simply by the fact that there is

a single payer in Canada who is politically constrained by other forces to be more sparing about the dollars that are spent.

Multiple financing, fragmentary financing of medical care is very expensive. And all the OECD nations of the world come along with Canada in illustrating that point. It is not some myth. It is not some magic. It is that the consequences of continuing inflation in medical care are born in a more concentrated form in single systems payer.

Thirdly, I would say that the Canadian example for us is an illustration of the benefits of universalism as compared to categorical coverage.

Not only is it the case that the universal scheme turns out to be popular, and politically popular, and therefore contributes in some sense to the political health of the country, but also it seems that universal coverage is the precondition for effective cost control. Because were there not universal coverage, it would be possible to shift costs backward to part of the fragments as is going on here in the United States, back to employees, back to patients in Medicaid, back to other actors from the federal to the state governments.

There is no place to hide in Canada when you try to cost shift. If you try to cost shift in the form of increasing the payments by patients, that means all patients are in the same boat. If you try to do so in the form of hidden charges above the fee schedule, so called extra billing, that too brings in the distinction between those who have extra money and those who do not.

And that became an enormous controversy in Canada in 1983-1984 when extra billing was increasing. And what the single pair did was a very simple device, a simple device which illustrates the point you were trying to make earlier, that while they are doing many things in medical care that turns out to be complex in practice, thinking about how to finance it is not all that complex.

What the Canadian government did in the wake of lots of extra billing that arose when they were constraining the fees was propose a federal law which was passed unanimously that said that for every dollar spent on an extra bill in your province, the grant of the federal government to your province will be reduced by a dollar. And that had the effect of providing the incentives for each province to do away with extra billing.

So, let me just summarize and stop. I think the Canadian system of medical care and finance provides an important alternative model of where to go from our present miserable circumstances I think the claims of its transplantability have been sometimes exaggerated as to how easy they are. But mostly they are exaggerated about how difficult they are. It is a similar system.

Certainly they show that it is possible, conceivable to do in a system like our own. But I do not say that that means that it is easy to do. Every interest group being paid in America to provide health insurance, or to consult about health insurance, or to market health insurance provides an important incentive not to draw that lesson from Canada. We have very well-paid advocates who have every reason in the world to regard the Canadian example, however desirable in principle, as not doable in practice. And I would urge skepticism about that claim.

[Prepared statement of Theodore R. Marmor, Ph.D., follows:]

PREPARED STATEMENT OF THEODORE R. MARMOR, PH.D., PROFESSOR OF PUBLIC POLICY AND MANAGEMENT, SCHOOL OF ORGANIZATION AND MANAGEMENT, YALE UNIVERSITY, NEW HAVEN, CT

I. Health Care Funding in Canada and the United States - An Inadvertent Natural Experiment on a Continental Scale

A. Very similar societies, with common language, closely related cultural and geographic experience, and tightly linked economic and communications systems.

B. Likewise very similar medical care "industries" - effectively identical technology and training programs. Medical care in both countries is predominantly provided by independent fee-for-service physicians, with admitting privileges at not-for-profit "voluntary" hospitals run by boards of trustees or municipalities.

C. Radically different processes of reimbursement for medical and hospital services, superimposed on similar delivery systems. Canada has not "socialized medicine" but "socialized insurance."

D. An opportunity to study the impact of alternative modes of funding on the health care delivery system in a quasi-controlled environment. Permits us to draw inferences about what might have happened, if different policy choices had been made at particular moments. It also expands the sense of the possible and provides clues as to the likely consequences of suggested policy interventions.

E. Development of for-profit institutions and a more "competitive" environment in the U.S. has created more differences in the past 10 years. This divergence, however, is more plausibly interpreted as a consequence of the differences in reimbursement systems in the two countries, rather than an external factor confounding their comparison.

II. The Basic Facts: It is socialized insurance, not socialized medicine.

A. History

1. By 1961 every province had a public program that reimbursed all "medically necessary" hospital services. Hospitals are reimbursed by direct budgetary allocation, rather than by fees for particular services. Individual patients are not charged for services.

2. By 1971, the system of public coverage had been expanded to cover physician services. In this case, physicians are reimbursed by fee-for-service but according to uniform fee schedules negotiated periodically between the provincial medical association and the provincial insurance program. The schedules differ across provinces.

B. Resulting arrangements

All residents of Canada are fully insured for all "medically necessary hospital and medical services" Access is universal and complete in the sense that there are no barriers to care. The anxiety and distress suffered by so many individual Americans as they contemplate the actual or potential impact of illness on their economic situation, has," as Bob Evans of British Columbia says, "no counterpart in Canada." Moreover those managing or paying for the system do not have to cope with the problems and costs raised by the multiplicity of manuevers to pass costs onto someone else." p.7 [check quote]

C. How are the costs borne?

1. From provincial/general revenues technically. But the federal government--in bloc grants that take the form of giving up tax revenues federally collected--contribute about 40% on average to the provincial coffers. That comes with key conditions: universality, comprehensiveness, portability, public administration, and dollar for dollar penalities for any billing above negotiated schedules. This results in quite similar programs across Canada, despite technical independence of provinces, but makes for a very big portion of provinical budgets (30% in Ontario, for example).

2. Some provinces require payment of a premium, but premiums are not related to risk and no one can be refused treatment because of unpaid premiums.

3. Cost-sharing: Greatly discouraged the 1984 Canada Medical Act, which authorized a dollar for dollar reduction of the federal grant.

4. Patients in long-term care, primarily in general hospitals, are charged a daily amount equal to 75% of basic pension.

C. The difference between the Canadian and the American approaches to health care reimbursement, therefore, can be summarized as:

1. Sole-source versus multiple-source funding

2. Universal versus categorical funding

3. General tax revenue versus mixed source funding

4. First dollar versus partial coverage

(See attached chart.)

III. Charge and Counter Charge: Canadian performance and the fears about cost

A. Affordability: universality does not imply national bankruptcy. There is no inevitable trade-off between accessibility and affordability.

Canada now spends about 1/4 less of its national income on medical care than the United States, despite having had almost identical spending

patterns in the post war period up to 1971. Almost all the difference is in medical and hospital care, since dentistry, out-of-hospital drugs, and public health not in the Medicare budget are rising at rates comparable to those in the United States. (See Figures 1 and 2.)

B. What explains the great cost differences between Canada and the United States?

1. Most obvious difference: the overhead costs of administering the reimbursement process itself. The multiplicity of different insuring agencies in the United States generates three kinds of costs:

   - The outlays on "costs of prepayment and administration": basically the difference between premiums paid in and benefits paid out.

   - The administrative costs included in the budgets of hospitals, medical practices, and other institutions, which are required to establish the eligibility of patients, and to deal with the claims requirements of insurers.

   - The monetary and nonmonetary costs of compliance with insurer requirements which are imposed on the insured.

   a. The first category--prepayment costs identified and reported in the expenditure data--are about five or six times as high in the United States as in Canada, and are rising rapidly. (See Figure 3.) The differential costs of administering the payment process, as opposed to paying for care, account for about one-half of one percent of GNP.

   b. In addition to these reported costs, the administrative costs included in the budgets of hospitals and the overheads of physicians' offices--thus included in total health expenditures, but not separately identified--are recognized by administrators as very large. They have been roughly estimated as perhaps another one-half percent of GNP.

   c. The extra costs of administering the U.S. insurance process amounts to close to a full percent of GNP, or about $40 billion. In addition to these costs, the multiple-source system imposes significant but unquantified costs of organization, compliance, and sometimes negotiation on patients and others, which are not counted in the overall expenditure statistics. The comparison shows that a multiple-source reimbursement system is a great deal more expensive to operate than a sole-source public system, and that at least up to now, efforts in the U.S. to create a more "competitive" system, or "managed" care, have added substantially to these overhead costs.

2. The second major component of the cost differential between the two systems is the difference in trends in physicians' fees.

   a. In the United States, physicians' fees have consistently risen faster than general prices ever since World War II. In Canada, this was also true prior to the introduction of the public insurance plans. After 1971, however, physicians' fees in Canada fell sharply in real terms. Since 1976 they have more or less kept pace with the general

inflation level. Thus another conclusion from the comparative experience is that uniform, negotiations, and binding fee schedules can significantly reduce the rate of escalation of physicians' fees.

b. Despite evidence from Canada that physicians do change their billing patterns to offset the effects of limits on the escalation of their fees, overall costs still rise less rapidly under fee negotiation.

c. The negotiation of fees is not a one-time process, but is more like labor-management negotiations, an on-going game between parties with strong opposed interests and the ability to respond to each other's tactical maneuvers.

3. The third major area in which Canadian and United States experience differs is in hospital budgeting. Costs per patient day have been rising steadily in both countries, but after adjustment for increases in hospital input costs, the "intensity of servicing"--the procedural content and expense of hospital care--has risen faster in the United States. But this difference in hospital servicing patterns is difficult to interpret, for two reasons:

a. First, as noted, are the differences in administrative costs. Outlays on patient care are much less different. We do not know if the extra costs of non-care activities are also growing more rapidly in the United States, although the increased emphasis on "managed" care, "competition," and marketing in the U.S. would certainly suggest that such increases are responsible for part of the difference in intensity of care.

b. Second, overall utilization of hospitals in Canada has been rising, while that in the U.S. has been falling. But the difference is accounted for by increased numbers of very elderly patients occupying beds in long-term care units of Canadian hospitals, in many cases until death. In the U.S., such patients would be in nursing homes. Use of genuine acute care beds by acute care patients in Canadian hospitals is actually falling. If one were able to isolate the pattern of servicing received by only the genuine acute care patients in Canada, it is quite possible that this would be rising as fast as in the U.S. Because Canada's present accounting systems combine acute and long-term care, the answer is simply not available.

c. The funding system in Canada does limit the numbers of specific pieces of expensive "high tech" equipment in hospitals, encouraging regionalization and sharing rather than inter-hospital competition. Moreover, such equipment seems anecdotally to be more intensively used, as are hospitals themselves. Occupancy rates in Canada run, on average, between 80% and 85%, with 95% typical of large metropolitan hospitals.

d. Finally, we know that prospective global budgeting combined with direct restrictions on capital spending has, in fact, led to less rapid escalation of hospital costs in Canada.

IV. Implications for the United States.

A. A Canadian-type health insurance system would remove the need to categorize our citizens into groups like "families" or "children" or "elderly" or "poor."

B. Universal coverage, with a single payor, has made health care affordable. But not every form of universality reins in costs. Universal access, through the current uncontrolled multi-party, multi-payor system, as opposed to universal coverage with one payor, would almost certainly add to America's health care costs. (That is presumably the reason why the AMA continues to espouse universal access, not universal insurance.)

C. The payment systems of Canada and Western Europe are controversial precisely because they work; they are a lightning rod for professional dissatisfaction.

It would be quite wrong to conclude, as the American media tend to do, that every system has its problems and therefore are all in the same boat.. While all struggle with the same problems, some struggle more successfully than others. Moreover, the costs are borne differently: "In Canada," writes one wit, "payors and providers fight, patients are in the audience. In the US, the patient is down in the ring and the contest appears much less equal."

Chart 1

Health Care Reimbursement
Canadian versus American Health Care Systems

Canada	United States
1. **Sole-source funding** Provinces are virtually only reimbursers for hospital and medical care.	**Multiple-source funding** Funds come from many sources and through many channels. No one agency has both fiscal responsibility for and administrative authority over total health care outlays within a single geographic jusridiction.
2. **Universal Coverage** All residents in every province and territory covered; portability assured.	**Categorical Coverage** Coverage depends on many aspects of status or behavior, such as present or past employment, payment of premiums, age, income level, or residence.
3. **Funds From General Tax Revenues** Burden of paying for health care is distributed in proportion to the overall tax system, and is an equitable or inequitable as that system.	**Mixed-Source Funding** Part of burden from general taxation; part (about 1/3) from the sick who pay for their own care; part by private insurance paid for by premiums that are more or less related to risk of illness.
4. **First Dollar Coverage** Full cost of care paid directly to provider, so that patient qua patient (as opposed to patient qua taxpayer) is not financially involved.	**Partial Coverage** Some American public programs pay provider directly, some reimburse patient who pays the provider; in either case the patient may be required to pay a significant share of the bill. Private insurance arrangements likewise offer a range from HMOs with no direct financial involvement of the patinet to partial reimbursement of the patient for money paid to the provider.

FIGURE 1

Total Health Expenditure as Share of GNP Canada & U.S., 1948 - 87

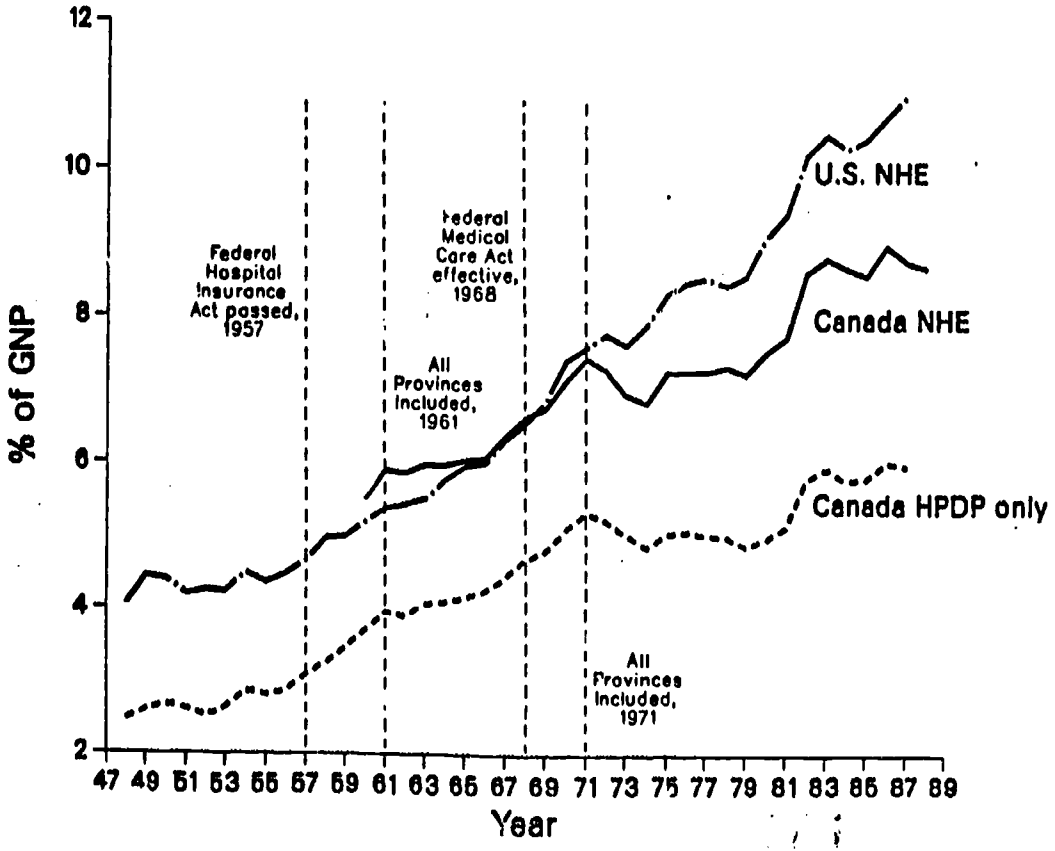


FIGURE 2

Hospital and MD Expenditure as Share of GNP Canada & U.S., 1948 - 87

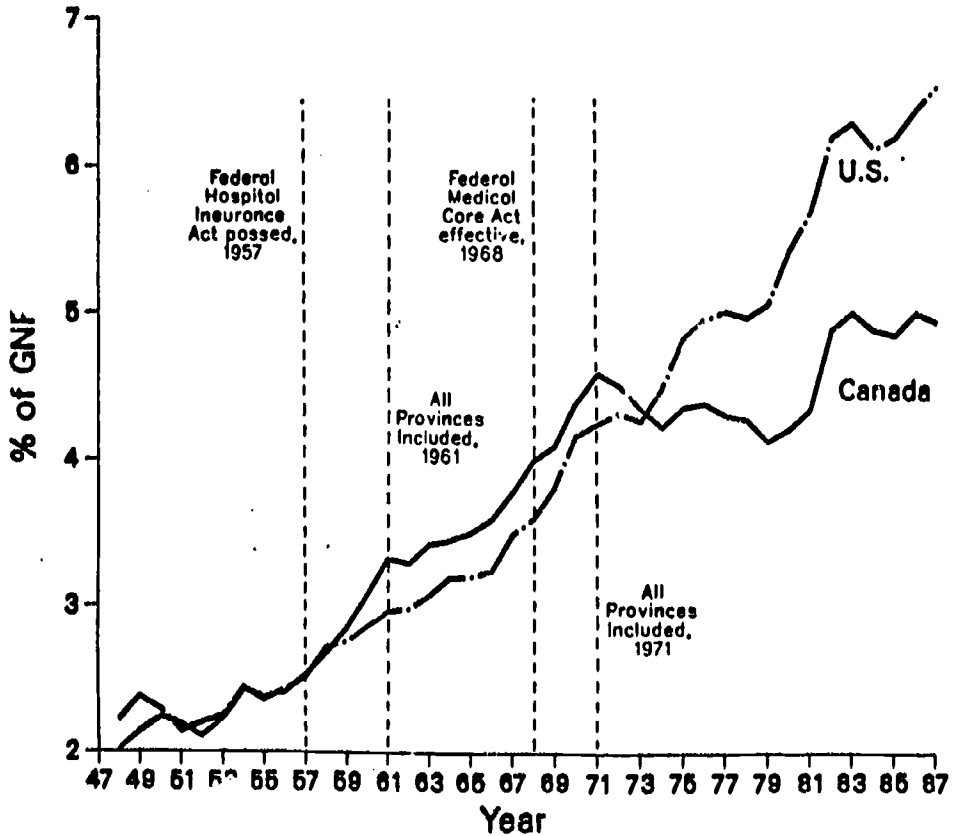
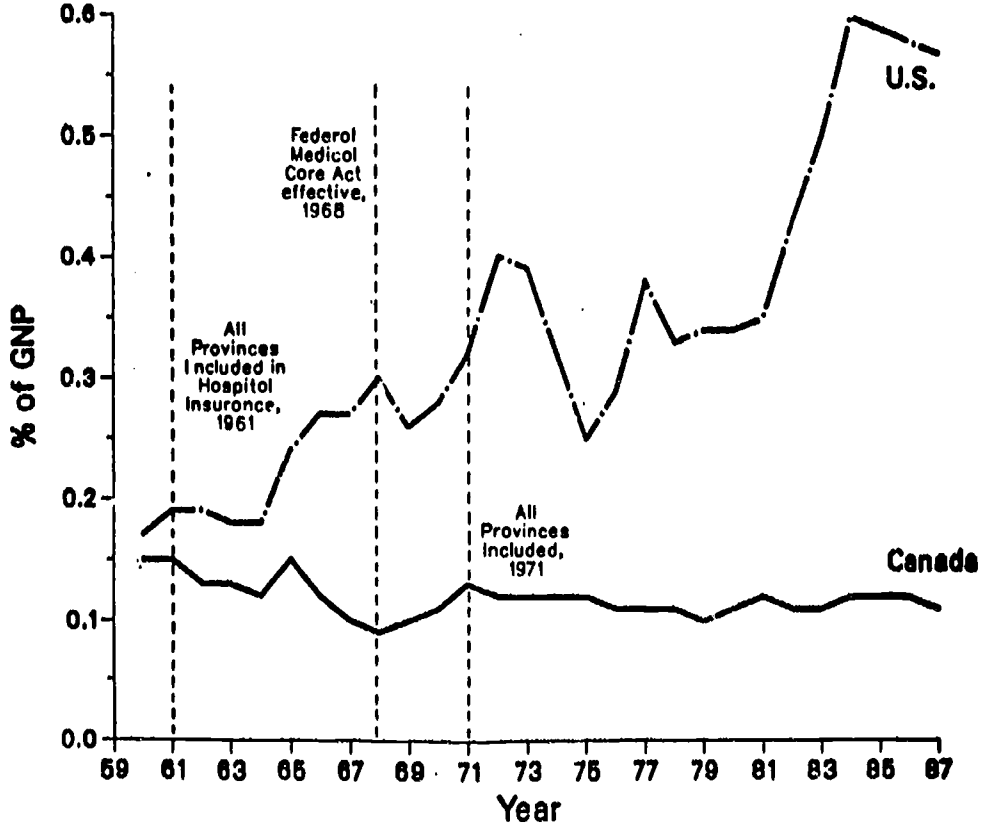


FIGURE 3

Costs of Insurance and Administration as Share of GNP Canada & U.S., 1960 - 87



Mr. MORRISON. Thank you.
Dr. Wolfson.

STATEMENT OF STEVEN WOLFSON, M.D., CHAIRMAN, HEALTH SYSTEMS PLANNING COMMITTEE, NEW HAVEN COUNTY MEDICAL ASSOCIATION, HAMDEN, CT

Dr. WOLFSON. Mr. Morrison, Mr. Evans, I appreciate and welcome this opportunity to appear before you. I am here today to speak to you as a physician looking to try to provide care to my patients in an era of limited resources, increasing statutory control, and bureaucratic regulations. And I have also had the mixed blessing of being a patient and of having members of my family ill as well, which has taught me much about the other side of this relationship.

In addition, I have chaired the New Haven County Medical Association's Health Systems Planning Committee, which has included the discussions of the group of physicians broadly representative of the medical community in the third Congressional district, who have been meeting with Congressman Bruce Morrison to explore the problems and the opportunities of the American health care system in this turbulent era. We began three years ago with a general review, and then discussed specific problems faced by health care providers, health care payers, our elected representatives, and most importantly, patients.

General agreement was reached in a number of areas.

Firstly, that the American profession and the American delivery system have experienced an extraordinary growth in their ability to treat or cure many major diseases, and to palliate or modify many others.

While doing so, our health care system has become unique in offering state of the art technology to a large number of people, coupled with flexibility, free choice, and an improving degree of patient's involvement and consent.

Unfortunately, we are also virtually unique among the developed countries of the world in providing no insurance to millions, incomplete insurance to millions more, and in imposing significant bureaucratic delay and administrative expense upon the delivery of health care.

Lastly, we grappled with the issue which seems to have dominated the public debate almost to the exclusion of all else; namely, the increasing cost of health care.

As we tried to address these problems, it became obvious to us that these conflicts could only be resolved by a system of universal health care insurance, which attempts to preserve the favorable aspects of medical care in this country.

Our unavoidable conclusion led us to develop a list of goals for such a universal health care insurance system. In broad outline these are:

1. Equal access for all persons;
2. Secure funding that is defended from the annual uncertainty of budget making;
3. Freedom of choice for both patients and physicians in directing the health care of individual patients; and

4. Professional direction of patient care decisions subject to review by peers.

The complete listing of the Medical Advisory Committee's goals are included with the printed copies of my oral remarks, which I believe you have already received. The goals were sent to numerous persons, groups, and organizations throughout this state. We solicited proposals from all for a system of health care insurance which would meet these goals.

Among those we contacted were the major components of the insurance industry, labor unions, consumer action groups, and business and industry coalitions within the state of Connecticut. The responses we received were frankly not helpful. Few of the respondents had chosen to look beyond their own immediate concerns, although most have been complaining bitterly about the rising cost of doing business as usual because of the expense of medical care.

Therefore, we have embarked upon an independent study of universal health care insurance systems which have been proposed in both the public and medical literature.

None of the systems we have examined so far is ideal. Some propose the imposition of a two tiered system. One tier for those with financial resources, and one tier for those without. Those who are insured would continue to be covered by welter of conflicting and duplicative insurance entities whose structure guarantees that insurance costs will continue to pose a major burden for our society.

Thursday's New York Times on the first page of the business section contained an article appropriately entitled, "Volleyball on Health Care Costs", and dealt with the fact that the government and private industry are "scrambling to make each other pay billions of dollars in medical bills for the elderly and the working poor."

In other proposals, the uninsured would be assigned to an independent benefit system, Medicaid, which has been receiving less and less support from our society. Even more inappropriately, proposals have been made to offer, to basically sell Medicaid as coverage for underinsured people, those with some, though limited resources.

Why would one buy an insurance policy that has historically been underfunded? Discussion of the fate of Medicaid, of the catastrophic insurance bill, and of Massachusetts' program for its uninsured suggested to us a pattern. Americans have only given consistent and firm support to programs that benefit us all. Only grudging support has been given to programs directed at limited segments of our nation. It therefore, is evident that it would take a universal system to receive wide spread and consistent support.

Other proposals we have reviewed envisioned a universal system of health care insurance, but they have not addressed issues of secure funding for covered health care needs. Funding for the medical care of the nation would be left to the annual uncertainty of budgeting and legislative negotiations. The recent debacle which occurred with the national catastrophic health care insurance legislation, and the inability or unwillingness of the Commonwealth of Massachusetts to fund its commitment to its own universal health care insurance system are examples of the worst sort.

To meet the health care needs of the American people reliably, stable funding on a long term basis is necessary to maintain appropriate levels of research and development, technology assessment, and the entire infrastructure of health care. A universal health insurance system ought not to lead us to expect second rate health care.

One of the areas that was covered in an earlier panel, for example, dealt with New York state. New York state is a heavily regulated state with major controls on expenditures. That has produced within the last five years a health care crisis in New York City that has resulted in incredible distress for everyone who has to undertake emergency care in the emergency rooms of the hospitals of the city of New York.

One inescapable conclusion we have reached, and one which most, if not all, advocates of the universal health care insurance system have either avoided or ignored, is the fact that implementation of a universal system will require greater expense. 31 million persons in the United States are uncovered by health care insurance. Their medical needs will have to be met.

In addition, converting from the current health care insurance system to a universal system would be a massive undertaking, which itself would be costly. Hence, a realistic approach should anticipate, at least for the short run, increased expenses. It is in the long term that we would expect to reduce the rate of increase in costs, and to provide for rational growth in the health care system. Events may have provided the means for this investment.

As the New York Times pointed out yesterday in its editorial column. "We need now to begin considering the allocation of the piece dividend which may follow the thawing of the cold war."

As was the case in Canada where universal health care insurance systems began on the provincial level twenty years ago, we can expect that the impetus for a national system may begin at the state level, a process which, in fact, has already begun.

In each state, a difficult political process will precede a decision to enact a universal healthcare insurance system. Once this decision is made, the actual implementation, itself, will take time if it is to be done well and responsibly.

We believe that the public debate should recognize from the beginning that systems in other countries will not necessarily work well in the United States. Budgetary planning in Canada, for example, has included the considerations that patients can be sent to the United States for treatment which requires state of the art technology or major capital expenditure. We have no other such neighbor to whom we can send our patients.

However, that America needs an American system should not deter us from examining others and from learning from their successes and failures. In this regard, our search for a unified American approach is continuing.

In conclusion, it is inevitable that major surgery for the United States health care insurance system will be considered. We consider that it is the physician's responsibility to participate actively in this process. It is our hope that the agenda for these discussions will not relate solely to bottom line budgetary issues.

If we simply cut funds from the health care budget, patients will suffer. We must address the need for equal access for all to an essential service. While doing so, we would hope to have more freedom for patients to choose the physician and the treatment most suited to their needs; more time for physicians to listen to patients; more efficient responses to changes in technology; and more dignity and humanity in the relationship between doctor and a patient.

[Prepared statement of Steven Wolfson, M.D. follows:]

PREPARED STATEMENT OF STEVEN WOLFSON, M.D., CHAIRMAN, HEALTH SYSTEMS PLANNING COMMITTEE, NEW HAVEN COUNTY MEDICAL ASSOCIATION, HAMDEN, CT

Mr. Chairman and members of the Select Committee on Children, Youth, and Families, I appreciate and welcome this opportunity to appear before you. I am here today to speak to you as a physician who works to provide care to my patients in an era of limited resources, increasing statutory control and bureaucratic regulations. I've also had the mixed blessing of being a patient and of having members of my family ill, as well, which has taught me much about the other side of this relationship.

In addition, I've chaired the New Haven County Medical Association's Health Systems Planning Committee which has included the discussions of a group of physicians, broadly representative of the medical community in the 3rd Congressional District, who have been meeting with Congressman Bruce Morrison to explore the problems and opportunities of the American healthcare system in this turbulent era. We began with a general review, and then discussed specific problems faced by healthcare providers, healthcare payors, our elected representatives, and most importantly -- patients.

General agreement was reached that:

1) the medical profession and the American healthcare delivery system have experienced an extraordinary growth in their ability to treat or cure many major diseases and to palliate or modify many others;

2) while doing so, our healthcare system has become unique in offering state-of-the-art technology to a large number of people, coupled with flexibility, free choice, and an improving degree of patients' involvement and consent;

3) unfortunately, we are also virtually unique among the developed countries of the world in providing no insurance to millions, incomplete insurance to millions more, and in imposing significant bureaucratic delay and administrative expense upon the delivery of healthcare;

4) last, we grappled with the issue which seems to have dominated the <u>public</u> debate, namely the increasing cost of healthcare.

As we tried to address the problems, it became obvious to us that these conflicts could only be resolved by a system of universal healthcare insurance which preserves the favorable aspects of medical care in this country.

Our unavoidable conclusion led us to develop a list of goals for such a universal healthcare insurance system. In broad outline, these are:

1) equal access for all persons;

2) secure funding that is defended from the annual uncertainty of budget-making;

3) freedom of choice for both patients and physicians in directing the care of individual patients;

4) professional direction of patient care decisions, subject to review by peers.

The complete listing of the Medical Advisory Committee's goals are included with the printed copies of my oral remarks, which I believe you have already received. The goals were sent to numerous persons, groups, and organizations throughout the state. We solicited proposals from all for a system of healthcare insurance which would meet the goals. Among those we contacted were the major components of the insurance industry, labor unions, consumer action groups, and business and industry coalitions within the State of Connecticut. The responses we received were not helpful. Few of the respondents had chosen to look beyond their own immediate concerns, although most have been complaining bitterly about the rising cost of doing "business as usual" because of the expense of medical care. Therefore, we have embarked upon an independent study of universal healthcare insurance systems which have been proposed in both the public and medical literature.

None of the systems we have examined so far is ideal. Some propose the imposition of a two-tiered system, one tier for those with financial resources and one tier for those without. Those who are insured would continue to be covered by a welter of conflicting and duplicative insurance entities whose structure guarantees that administrative costs will continue to pose a major burden. In other proposals, the uninsured would be assigned to an independent benefits system -- Medicaid -- which has been receiving less and less support from our society. Even more inappropriately, proposals have been made to offer Medicaid as a coverage for under-insured people with some, though limited, resources. Why would one buy an insurance policy that has historically been under-funded? Discussion of the fate of Medicaid, of the catastrophic insurance bill, and of the Massachusetts program for the uninsured suggested to us a pattern. Americans have only given consistent and firm support to programs that benefit us all. Only grudging support has been given to programs directed at limited segments of our nation. It, therefore, is evident that it would take a universal system

to receive widespread and consistent support.

Other proposals we have reviewed envisioned a uniform universal system of healthcare insurance, but they have not addressed issues of secure funding for covered healthcare needs. Funding for the medical care of the nation would be left to the annual uncertainty of budgeting and legislative negotiations. The recent debacle which occurred with the national catastrophic healthcare insurance legislation and the Commonwealth of Massachusetts' inability and/or unwillingness to fund its commitment to its own universal healthcare insurance system, are examples of the worst sort. To meet the healthcare needs of the American people reliably, stable funding on a long-term basis is necessary to maintain appropriate levels of research and development, technology assessment, and the entire infrastructure of healthcare. A universal healthcare insurance system ought not to lead us to expect second-rate healthcare.

One inescapable conclusion we have reached and one which most, if not all, advocates of a universal healthcare insurance system have either avoided or ignored is that the implementation of such a system will require greater expense. Thirty-one million persons in the United States are uncovered by healthcare insurance. Their medical needs will have to be met. In addition, converting from the current healthcare insurance system to a universal system would be a massive undertaking, which, itself, would be costly. Hence, a realistic approach should anticipate increased expenses. It is in the long-term that we would expect to reduce the rate of increase in costs and to provide for rational growth in the healthcare system.

Realistically, we should understand that the decision to implement a universal healthcare insurance system and then its actual implementation will not take place overnight. As was the case in Canada, where universal healthcare insurance systems began on the provincial level, we can expect that the impetus for a national system will begin at the state level, a process which, in fact, has already started. In each state, a difficult political process will precede a decision to enact a universal healthcare insurance system. Once this decision is made, the actual implementation, itself, will take time if it is to be done well and responsibly.

We believe that the public debate should recognize from the beginning that systems in other countries will not necessarily work well in the United States. Budgetary planning in Canada, for example, has included the consideration that patients can be sent to the United States for treatment which requires state-of-the-art technology or major capital expenditure. However, that America needs an American system should not deter us from examining others and from learning from their successes and failures. In this regard, our search for a unified American

approach is continuing.

In conclusion, it is inevitable that "major surgery" for the United States' healthcare insurance system will be considered. We feel that it is our responsibility to participate actively in this process. It is our hope that the agenda for these discussions will not simply relate to bottom-line, budgetary issues. If we simply cut funds from the healthcare budget, patients will suffer. We must address the need for equal access for all to an essential service. While doing so, we would hope to have more freedom for patients to choose the physician and the treatment most suited to their needs; more time for physicians to listen to patients; more efficient responses to changes in technology and more dignity and humanity in the relationship between doctor and patient.

Respectfully submitted:

Steven Wolfson, M.D.
Chairman
Health Systems Planning Committee

GOALS

FOR A

UNIVERSAL HEALTHCARE INSURANCE SYSTEM

PREAMBLE

Beginning in March of 1986, Congressman Morrison and a broad representation of physicians initiated a series of discussions of our healthcare system. We reviewed the American system, other forms of voluntary healthcare delivery and payment, and found a number of problems:

1) Many patients in this affluent country have no healthcare insurance and many receive inadequate healthcare.

2) Healthcare insurance modalities have multiplied with resultant loss in efficiency, increased administrative cost, and rampant confusion for healthcare users and providers.

3) Both patients and physicians seem to be losing control over the delivery and receipt of healthcare.

We studied the concept of a universal healthcare insurance system. We have developed what we feel to be an appropriate set of goals for such a system. We propose to solicit plans for mechanisms to achieve these goals.

A. Access --

1. The system should provide that individuals, regardless of income, have equal access to quality healthcare.

2. The system should provide incentives to promote equal access and to improve the healthcare system.

B. Funding --

1. The system should provide a level of funding adequate to ensure (a) equal access to healthcare services for all individuals (b) reasonable levels of medical research and development activity, (c) education of healthcare personnel, and (d) appropriate maintenance of the healthcare infrastructure. Funding priorities should be based upon actuarial estimates of needs.

2. The system should be funded through public and private sources (including employers), and, to assure that the expense of healthcare services is borne fairly, the cost to subscribers should be based upon an individual's ability to pay. The tax system would be used to determine an individual's ability to pay and to assess appropriate funding from subscribers.

C. Structure --

1. The system should replace the current employer-based group insurance system with a subscriber-based system in which all individuals would be required to participate.

2. The system should have its policy-making decisions formulated by an independent, trust-like entity. It would include representation from the government, the public, and the healthcare sectors.

3. The system should be administered by the private sector, which would be allocated a percentage of the premium collected for the purpose of encouraging efficiency and assuring that as much of the premium collected as possible would, in fact, be used for funding the healthcare delivery system. The insurance function (risk) might be discharged by the government or by the private sector under government guidelines.

D. Quality of Care and Proper Utilization

1. The system should promote quality of care, with adequate means to minimize and control abuses.

2. The system should assure that decisons affecting quality of care are made by those trained to make such decisions subject to review by peers.

3. The system should provide adequate incentives to ensure that healthcare professionals are motivated to strive for excellence and efficiency.

4. The system should be structured to foster the physician-patient relationship. This would include as a priority a reasonable degree of individual patient choice of his/her physician and of alternative treatment modalities.

Supplement

Mr. Chairman and members of the Select Committee on Children, Youth, and Families, I am submitting the following as a written supplement to my oral testimony at the December 11, 1989 field hearing of the Committee. In my oral presentation, I based my comments upon a shared assumption that the current healthcare system is inadequate and must be replaced by a more rational structure. My hope, here, is to furnish an underpinning for the assumption I made and to give, as well, some factual context for any discussion about adequately insuring the American people's healthcare needs.

The current population of the United States stands at 243,915,000.[1] Approximately 214 million persons are under the age of sixty-five.[2] Almost 30 million are at or over the age of sixty-five. Of the 214 million persons under the age of sixty-five, thirty-one million are uninsured, which represents about 14.5 percent of this category and about 12.7 percent of our entire population.

When the Employee Benefit Research Institute had estimated the number of uninsured at 37 million, it placed the percentage of children under the age of eighteen who were affected at thirty-three percent of the uninsured and those persons earning under $19,999 annually at sixty-three percent (see Exhibit 1, attached). Using the revised estimate of thirty-one million, these percentages equal 10,230,000 children and 19,530,000 persons earning less than $20,000.00 per year.

However astonishing these numbers are, we cannot even begin to guess how many more Americans are underinsured for their healthcare needs. There is no question in my own mind but that these numbers, by themselves, indict the current structure under which healthcare insurance is provided.

For those who purchase or receive healthcare insurance coverage, the expense is increasing, making it more and more difficult for them and/or their employers to afford. An article from The New York Times' June 29, 1989 issue, "Debating Canadian Health 'Model'" (see Exhibit 2, attached), reported that "(e)xecutives at the Ford Motor Company are dismayed that the auto maker is spending the equivalent of $311 a vehicle for healthcare for its employees, while in Canada, a half-hour drive from Ford's headquarters in Michigan, the cost is $49.80." There is little wonder that American employers trying to compete in what has become a world market find it difficult to support healthcare expenses when those expenses are more than six times greater in this country. Nor is it any wonder that employers in growing numbers have instituted cost-sharing health insurance plans.

Expenditures for medical care in the United States are projected to rise to twelve percent of our GNP (gross national product) during 1990. The percentage of GNP spent on healthcare has grown steadily since 1965, when it accounted for 5.9 percent of GNP.[3]

From my extensive reading about the subject, it does not appear to

me that we have been able to determine whether any percentage of the GNP spent on healthcare is a right amount or a wrong amount. We just don't know. However, the last decade has driven home the point that our national resources are not infinite.

This conclusion imposes upon all of us at least two significant responsibilities:

- First, we must be sure that the money we expend is spent wisely. As a society, we must, therefore, come to grips with difficult moral choices, such as whether we are better off putting 'X' number of dollars into kidney dialysis or would those dollars better be spent on prenatal care, on nutrition, on defense, on housing, or on environmental control. Frankly, setting medical priorities poses terrible and difficult decisions that cannot be made by an individual patient or an individual physician. You might remember, for example, a survey of persons who had experienced a life-threatening medical problem and been placed in intensive care. They were asked if they would again undergo that physical and financial ordeal if they knew that they would only live for an additional month. Seventy percent said they would.[4] The will to live is an incredible thing. According to a February 6, 1989 **Business Week** article, "High-Tech Health Care: New Medical Technologies Can Save Lives -- At A Price" (see Exhibit 3, attached), ". . . each of us racks up

85% of our health care expenses in the last two years of life."

- Our second responsibility, I would suggest, is to decide as a matter of policy whether our healthcare resources should be rationed by making complete medical care available to only those who can afford it. In my opinion, a market allocation of limited healthcare resources is immoral. We are now doing this. The State of Oregon, for example, decided that $2.3 million of its Medicaid budget being spent upon heart, liver, bone-marrow and pancreas transplants would provide hundreds of needy pregnant women with prenatal care. This reallocation would help to avoid medical expenses for severely premature births and other birth anomalies.[5] This debate, though, confined as it was to Medicaid recipients, meant that a small segment of our society was restricted to receiving either transplants or prenatal care, but not both. It is my belief that the American people will only support a system of self-disciplined rationing if it is equitable, if it applies equally to everyone, regardless of income.

We have also in place now a healthcare system in which a multiplicity of insurers are competing to attract insureds, at least in part by the benefits they offer. This makes it difficult, perhaps even impossible, to enforce a discipline upon what benefits are provided. In a study published during 1986, Himmelstein and Woolhandler studied

healthcare expenses for 1983, concluding that a universal healthcare insurance system could save $21.4 billion in administrative costs.[6] Evans and Lomas, in an article three years later,[7] referred to the earlier piece, stating that "(t)his would be 6 percent of total healthcare costs, or 0.63 percent of the GNP in 1983 -- leading to the startling conclusion that the costs of running the American payment system itself, independent of the costs of patient care, may account for more than half the difference in cost between the Canadian and the U.S. systems" (underlining added). More recent estimates have projected saving as much as $150 billion, which amounts to twenty-five percent of the $600 billion or so we are currently spending on healthcare. I think there can be little argument about the fact that as much as possible of the healthcare dollar should be spent on medical care, not paperwork. It is estimated that Canada spends only $21 per person (in Canadian dollars) for administration, while the United Stated spends $95 per person (in American dollars).[8]

The indictment of our current system, i.e., statistically incomplete access, extends to administrative inefficiency, but also includes confusing and duplicative coverage for those who fully participate in insured healthcare. Cost has been a growing impediment to access to medical care. Confusion about how the healthcare system operates is running a very close second. Again, the multiplicity of insurance coverages that exist, the variations they present in their covered benefits, and the array of requirements each has for the ultimate payment of a claim for medical services is bewildering. It

used to be that the bewilderment was mostly that of the insureds -- the patients. I confess to you that providers, today, are almost as bewildered as their patients.

In Connecticut, during the last fifteen years, I have watched the establishment of at least eleven HMOs (health maintenance organizations). They are:

1. Constitution Health Network
2. HealthCare, Inc.
3. M.D. Health Plan, Inc.
4. Liberty Health Plans, Inc.
5. Phyeicians Health Services
6. CIGNA Health Plan of Connecticut, Inc.
7. Kaiser Permanente of Connecticut
8. Community Health Care Plan
9. U.S. Healthcare
10. Partners Health Plan of Southern New England
11. Suburban Health Plan, Inc.

Of these, two have become insolvent, although one -- HealthCare, Inc. -- was salvaged by Blue Cross & Blue Shield of Connecticut, Inc. In addition, several PPOs (preferred provider organizations) have been established and I am aware of several more on the drawing boards. This is in addition to the numerous traditional indemnity insurers that do business here, as well as Medicare, Medicaid, and Workers'

Compensation. Many of these insurers offer more than one plan, and each has its own benefit permutations and plan requirements.

One of the more articulate statements on this subject appeared in the August 31, 1989 issue of the New England Journal of Medicine. Titled "Health Care Rationing Through Inconveniences: The Third Party's Secret Weapon" (see Exhibit 4, attached), the piece describes better than I can the overlay of bureaucracy and red tape that has engulfed our healthcare system. Anyone trying to understand how impossible the system is becoming should read this article.

Albeit for different reasons, it is evident that healthcare providers, payors (whether government, employers, or individuals), and patients are, in increasing numbers, reaching the conclusion that the healthcare system we now have is unworkable and growing more so daily. Only third-party payors appear to be consistently supporting a 'more-of-the-same' approach.

The alternative to our system of financing medical care most often cited as being desirable is the Canadian model. Because Canada as a society most closely resembles our own, it does appear to have much to recommend it. The fact that it is a system of social insurance, but not socialized medicine, is particularly appealing from my point of view as a provider.

Nonetheless, there are differences between the societies of Canada

and the United States, and a rational system of healthcare insurance in our country should be designed to account for them. Moreover, Canada's system of healthcare insurance evolved over a period of time and has now been in place for more than twenty years. Some elements of it have worked better than others. We should, I believe, borrow what is best and most compatible with the needs of the United States. We should also remember that many aspects of our own system are astonishing success stories. Any alternatives that we look at should retain what is best about our own system. The numerous Canadian patients who receive state-of-the-art diagnoses and treatment in the United States are testimony to tha success of medical research and development, and of the rapid application of current technology here. This factor also represents a cost savings to Canada. I would recommend to your attention an article from the New England Journal of Medicine: "Controlling Health Expenditures -- the Canadian Reality" (see Exhibit 5, attached).

The last point I would like to make is that the healthcare insurance system we design should include incentives that strengthen the physician-patient relationship. I am not promoting financial incentives here, but much of what has been done during the past fifteen years to control healthcare costs has served to alienate patients from providers with few positive results. For example, it appears that second opinion programs do not save money or significantly alter treatment. They do, however, establish an inherent attitude of distrust. The physician-patient relationship is a clinical tool that

affects the quality of care we are able to provide. Creating an adversarial atmosphere to heighten competition or for the sake of regulating providers' behavior damages our ability to give good care to our patients and has fueled the malpractice crisis we have had since the mid-seventies. The doctor-patient relationship is also not helped by financial incentives to deliver less care. I would hope that a healthcare system we adopt or create can control the rate of increase in expenses and restore trust between and among the parties involved in that system.

I have appreciated the opportunity afforded to me to testify before the Select Committee on Children, Youth, and Families, as well as the opportunity to submit these additional comments for the Committee's record. I hope that my thoughts on the subject of universal healthcare insurance have been helpful. If I can be of any further assistance, please do not hesitate to call upon me.

Respectfully submitted,

Steven Wolfson, M.D.

Steven Wolfson, M.D.
Chairman, Health Systems
Planning Committee

[1] U.S. Bureau of the Census Current Population Report, Series P-25, #5199171022.

[2] Ibid.

[3] "Curbing the High Cost of HealthCare," Nation's Business, September 1989.

[4] Louis Harris poll

[5] "Who Should Receive Medical Aid," New Haven Register, May 28, 1989.

[6] "Cost Without Benefit: Administrative Waste in U.S. Health Care," New England Journal of Medicine, 1986, 314:441-5.

[7] "Controlling Health Expenditures -- The Canadian Reality," New England Journal of Medicine, 1989, 320-571-7.

[8] Ibid.

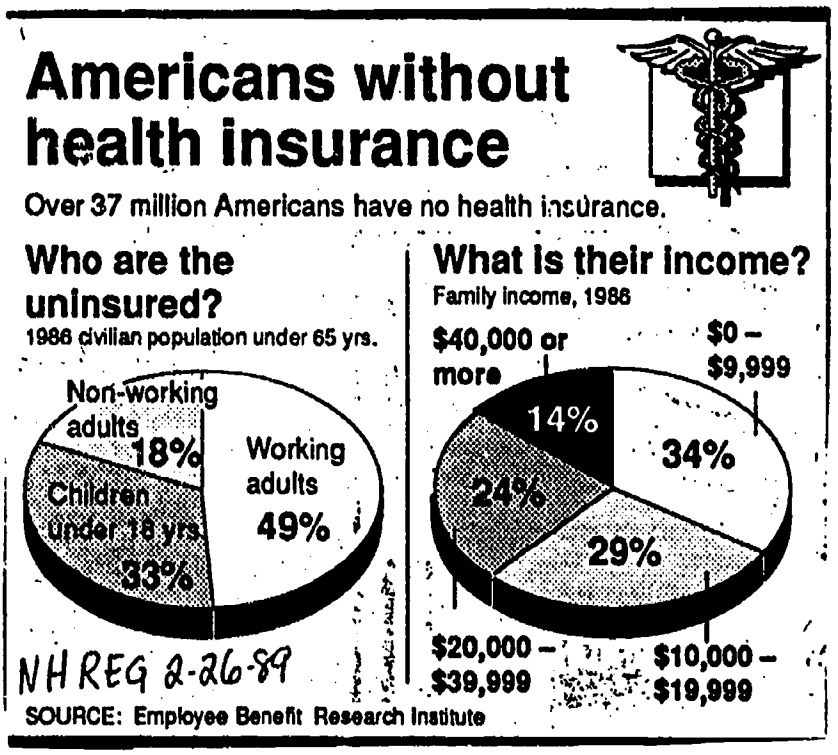

Americans without health insurance
Over 37 million Americans have no health insurance.
Who are the uninsured?
1986 civilian population under 65 yrs.
Non-working adults 18%
Children under 18 yrs. 33%
Working adults 49%
What is their income?
Family income, 1986
$40,000 or more
14%
$0 – $9,999
34%
24%
29%
$20,000 – $39,999
$10,000 – $19,999
NHREG 2-26-89
SOURCE: Employee Benefit Research Institute

EXHIBIT 1

EXHIBIT 2

THE NEW YORK TIMES - JUNE 29, 1989

Debating Canadian Health 'Model'

By MILT FREUDENHEIM

Special to The New York Times

TORONTO — Executives at the Ford Motor Company are dismayed that the auto maker is spending the equivalent of $311 a vehicle for health care for its American employees, while in Canada, a half-hour drive from Ford's headquarters in Michigan, the cost is $49.80.

Striking differences like this are leading a growing number of American employers, economists and legislators to examine Canada's taxpayer-financed system of national health care. They are looking for solutions not only to the problem of rising health costs but also to the lack of insurance for 37 million Americans.

But the new scrutiny has produced sharp debate. While some employers who pay for care are inclined to see the bright side of the Canadian system, many doctors and hospital administrators are skeptical.

'Deficiencies and Problems'

Indeed, the American Medical Association decided at its semiannual meeting last week to "document and publish the truth about the deficiencies and problems that characterize Canadian health care."

By some measures at least, Canadians are healthier than Americans. They live longer, on average, and their infant mortality rate is 25 percent lower, according to the Employee Benefit Research Institute, a nonprofit research center in Washington. What is more, all Canadians are guaranteed care, at no charge.

Yet Canada has held health spending to 9 percent of its gross national product, while in the United States, spending on health has spurted to 11.3 percent of the G.N.P.

Both critics and proponents of Canada's system say its costs are lower because doctor and hospital fees are tightly controlled and the purchase of advanced technology lags behind that in the United States. The result can be longer waits for certain kinds of care.

"They really believe in equity and equal access and are willing to go without some things that we take for granted," said Senator David F. Durenberger, Republican of Minnesota, and vice chairman of a Senate-House commission on comprehensive health care, after a visit here recently. "The kind of rationing they have is the same kind we should have. Rather than pay the price in dollars, they pay the price in waiting time."

Administrative costs are also lower in Canada, where overhead and paperwork absorbs about 3 percent of the health budgets. In the United States, where most health care is paid for by Federal, state and private insurers, the 1,500 private insurers have overhead costs of close to 12 percent, covering items like marketing, reserves for future claims, taxes and profits, Federal data show. The Federal Medicare and Medicaid programs have overhead costs of about 3.5 percent.

But a committee report at the A.M.A. meeting denounced Canada's system as "socialized medicine managed by an ever-enlarging and more expensive bureaucracy, financed by ever-increasing taxation and featuring rationing, shortages, health-care waiting lists and an absence of private-sector alternatives."

Spokesmen for Canadian medical associations register similar objections.

Canadians say they like their system, however. In recent polls by Gallup Canada Inc. and Louis Harris & Associates, sizable majorities said they were satisfied with their health services.

"We get very few complaints," said Bill Van Gaal, president of a Canadian Automobile Workers Union local in Oakville, Ont., that represents 4,200 of Ford's 16,000 Canadian employees. He said retired Canadian auto workers in the American Sun Belt had medical coverage inferior to that at home.

"Health care is one issue that transcends all political boundaries," said Perrin Beatty, the Federal Health Minister and a Conservative Party leader. "It is taken as an article of faith by Canadians that they are entitled to health care as a basic right."

Companies Seek Alternatives

In the United States, House and Senate committees on health have been summoning experts from both countries to Washington to appraise the Canadian system. Many American executives are also interested, as they search for alternatives to the enormous amounts some companies spend for employee health care.

"We don't see our employees in Windsor, Ont., coming over to Detroit for medical care," said Walter B. Maher, director of the Chrysler Corporation's human resources office in Washington.

American employers say that doctors and hospitals shift onto their bills the costs of people who cannot pay or who are covered by Government programs that have tightened their belts.

Canadian employers, by contrast, pay a fraction of the health program's costs through premiums and payroll taxes. The main financing comes from taxes paid by individuals, which are generally higher than in the United States.

The 10 Canadian provinces negotiate annual budgets with the province's medical and hospital associations, effectively setting a ceiling on total expenditures. The associations then allot fees to family doctors and specialists.

The hospital groups have also tried to hold down nurses' salaries. Nurses in British Columbia have been on strike, demanding higher pay, since June 14.

Doctors are paid out of province funds and are forbidden to charge patients, although some charge nominal fees for "equipment," said Dr. Michael Wyman, a board member of the Ontario Medical Association. "In the case of an abortion, that might amount to $200" ($166 United States), he added.

Unlike Britain's National Health Service, which pays general practitioners an annual amount for each patient on their list, Canada has no unregulated doctors or hospitals available for affluent patients.

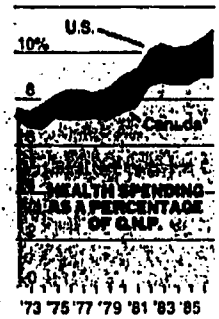
Dr. Wyman and other physicians said budget restrictions on hospitals

Free medical care, but longer waits for certain treatments.

caused delays of up to six months for non-emergency surgery or special tests at leading urban medical centers. The provinces limit hospital purchases of equipment, from conventional X-ray machines to expensive computerized scanners, magnetic resonance imagers and lithotripters used to pulverize kidney stones. One reason for this is the belief that not every hospital in a community needs every piece of medical equipment.

Canadian patients are occasionally sent to American hospitals in Buffalo, Detroit and Seattle and the Mayo Clinic and Cleveland Clinic for prompt attention.

Comparing Health Care Systems



*Estimate
† In thousands

EXAMPLES OF DIFFERING INVESTMENTS IN TECHNOLOGY	Canada	Population Units Per Unit†	United States	Population Units Per Unit†
Cardiac Catherization Labs Diagnosis and treatment of cardiovascular disease	31	616	1,500\	166
Lithotripters Pulverize kidney stones and gallstones	4	6,325	228	1,096
Magnetic Resonance Imagers Diagnosing a wide range of diseases	12	2,108	1,375	182

Source: Canadian Health and Welfare Ministry, U.S. Health Care Financing Administration

Because of the cost constraints, medical fees in Canada are usually lower. The bill for one Canadian Ford employee's medical emergency in the United States was $21,000, four times the usual Canadian charge, said James S. King, manager of pensions and employee insurance at Ford of Canada in Oakville, 40 miles from Toronto.

Dr. Jean-Marc Dumas, a radiologist and president of the Bellechasse Hospital in Montreal, said his American brother-in-law recently paid $22 in Boston for a chest X-ray reading that would have cost $4.50 in Montreal.

But in a widely publicized case, Charles Coleman, a 63-year-old diamond cutter, died in December, a week after a coronary bypass operation at St. Michael's Hospital in Toronto that had been put off for four months.

In a cover story on "the crisis in health care," MacLean's, a Canadian news magazine, said the operation had been postponed because of a shortage of beds in the hospital's intensive-care unit. But health professionals like W. Vickery Stoughton, an American who is president of the Toronto General Hospital, said there had been a medical need to delay the operation.

'Orchestrated' Outrage Seen

"The outrage was orchestrated," said Dr. Allan Detsky, an internist at Toronto General who briefed a subcommittee of the Senate Finance Committee on the Canadian health system recently.

"The rhetoric of underfunding, shortages, excessive waiting lists and so on is an important part of the process by which providers negotiate their share of public resources — including their own incomes," said Robert G. Evans, an economics professor at the University of British Columbia.

Incomes can be substantial. In populous Ontario, where more than one-third of Canada's 26 million people live, the average gross income of full-time practicing physicians is $238,000 ($198,000 in American currency), said Elinor Caplan, Ontario's health minister. After subtracting for office and overhead expenses, their pretax income is about $113,000 (United States), compared with $146,200 for self-employed American doctors. Incomes of physicians who are researchers and others on salary are lower in both countries. But fees in Canada have not kept up with inflation.

In Montreal, where the province authorities have set three-month ceilings on physician income, many doctors take two-week vacations every quarter, Dr. Dumas said. Hospitals shave budgets by holiday closings of wards and operating rooms.

"Patients back up in the emergency room," said Dr. J. Edwin Coffey, an obstetrician and secretary of the Quebec Medical Society. "We think the system is breaking down."

Dr. John O'Brien-Bell, president of the Canadian Medical Association, said that because patients do not pay, "unlimited public expectations" strain the system, as evidenced by overcrowded emergency rooms and waiting lists for diagnostic tests and surgery.

"We are beginning to move off the delivery of the highest standard, which was the premise of Canadian Medicare," he said.

But Dr. Michael Rachlis, a Toronto public health physician, said health care money could be better used on social programs and preventive medicine. "Social and economic factors such as employment, cigarette smoking and housing are far more important for people's health than hospitals and physicians' services," he added.

Radical changes in the Canadian system do not appear in the offing, however. "This system needs to be improved; we have to face up to the costs," said Jacques Garon, research director of the Conseil du Patronat, the Quebec employers association. But a "United States system" is not an option, he added. "Public opinion," he said, "is really in favor of keeping this kind of system."

Mr. MORRISON. Thank you very much.
Dr. Krassner.

STATEMENT OF LEONARD S. KRASSNER, M.D., PRESIDENT, CONNECTICUT CHAPTER, AMERICAN ACADEMY OF PEDIATRICS, WALLINGFORD, CT, ACCOMPANIED BY ELSA STONE, M.D., VICE PRESIDENT AND CHAIRPERSON, COMMITTEE ON HEALTH FINANCING, CONNECTICUT CHAPTER, AMERICAN ACADEMY OF PEDIATRICS, NORTH HAVEN, CT

Dr. KRASSNER. Mr. Morrison, Mr. Evans, my name is Leonard Krassner, and on my left is Elsa Stone. We represent the American Academy of Pediatrics today. I am very pleased to be here, and I am also very pleased I think that we are on the right panel.

I have been asked to discuss two topics with you today. One is the health insurance bill on access that we helped pass here in Connecticut, and the other is to give you a general idea about the proposed child care bill being drafted by the National American Academy of Pediatrics.

The paramount concern of the AAP, both nationally and locally, has been the health and well being of children. Children are poorly served in our society. And it is embarrassing that the United States and South Africa are the only two industrialized countries that do not provide universal health insurance coverage for their children. Connecticut has the highest infant mortality rate in New England. It is third in the percentage of AIDS cases in childhood, and has approximately 86,000 children with no health insurance.

During the last session of the state legislature, we successfully lobbied for the passage of a bill which requires that as of October 1, 1989, all new or renewed group health insurance policies include coverage for preventive pediatric care from birth through age 6. This bill is far more limited than we desired. We were aware that the only age group with a rising mortality rate is the teenage years, but we were unable to have them included in our bill.

As written, the present bill leave intact all deductibles and copayments that are part of the parent's existing policy. Needless to say, if these are high, they act as a continued barrier to access. The bill does, however, promise preventive pediatric care from birth to age 6 according to the following schedule:

Every 2 months from birth to 6 months;
Every 3 months from 9 to 18 months; and then
Annually from 2 through 6.

The National Academy of Pediatrics' proposal for universal access for children and pregnant woman is a much broader bill than our state's legislation. However, it too is a limited bill. And it does not cover adult men and non-pregnant females.

It does, however, focus on a segment of our society, which is most vulnerable—the unborn and children. And we suggest that by implementing this partial coverage now, we could work out a myriad of details of a program with broader health coverage that would go into effect later on.

The program as conceived is based upon the fact that most health insurance in America is provided through employers. The availability of quality employer-based insurance, especially for de-

pendents, is declining because economically pressed employers have either dropped dependent health insurance, reduced the benefit packages, or required employees to pay a higher premium share for dependent coverage.

For those patients who do have insurance, the benefits usually cover anesthesia, surgery, and the doctor, but do not reimburse for the less dramatic preventive functions that might have eliminated the problems in the first place.

Our proposal is designed to assure universal access to health insurance with a federally mandated standard benefit package for all children through age 21 and for pregnant woman. The standard package will be designed to ensure quality of care with benefits divided into three categories: preventive benefits, primary/major medical benefits, and care-coordinated benefits.

Coverage will be available either through employer based insurance or a state administered fund, thus ensuring a one tier insurance system.

Employers who offer insurance to their employees will have the option of providing coverage for dependents through the standard benefit package as defined by the legislation, or to pay a payroll tax of about 3.5 percent to the state funds.

In addition to the payroll tax, the state administered insurance fund will be financed through federal and state Medicaid funds, plus premiums and co-payments. For families with incomes below 130 percent of the poverty level, no contribution will be required for those whose income is between 130 and 200 percent of poverty, a sliding scale will be applied.

Our proposal suggests a dual form for Federal and state governments. The Federal government will ensure high standards, while the states will enjoy flexibility in administration and management.

The benefits of our program are divided into three categories:

1. Preventive Benefits: Preventive care visits at clearly defined intervals, pre-natal care, care of newborns, and child abuse assessment. Regardless of the family's income level or insurance system, no co-payments or deductibles will be applied.

2. Primary/Major Medical Benefits: This includes care for acute and chronic illness, hospital care, subspecialty consultations, emergency room care, drugs, and laboratory tests. And there will be a maximum deductible contribution of $200, and a maximum co-payment of 20 percent of the total charges for the services in this category.

3. Case Managed Benefits: This includes services such as mental health, substance abuse, and treatment of developmental and learning disabilities. And there will be a case management of the benefits in this category.

I included two pages on my printed form that I sent in. One copy is of the state bill, and the second, an overview of the national bill. We will be very happy to answer any questions about this, but we feel that this an appropriate step to take while Panel 2 is deciding on how best we should go. That this is something that can be instituted very early and be used as a model.

Thank you.

[Prepared statement of Leonard S. Krassner, M.D., follows:]

PREPARED STATEMENT OF LEONARD KRASSNER, M.D., PRESIDENT OF THE CONNECTICUT CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, ACCOMPANIED BY ELSA STONE, M.D., VICE PRESIDENT OF THE CONNECTICUT CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, WALLINGFORD, CT

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Mr. Chairman and Members of the Committee:

I am Leonard S. Krassner, MD, president of the Connecticut Chapter of the American Academy of Pediatrics. I am accompanied today by Elsa Stone, MD, vice president of our chapter and chairperson of our committee on health financing.

I have been asked to discuss two topics with you today. One is the health insurance bill we helped pass here in Connecticut and the other is to give you a general idea of the proposed childcare bill being drafted by the national American Academy of Pediatrics.

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The program, as conceived, is based upon the fact that most health insurance in America is provided through employers. The availability of quality employer-based insurance, especially for dependents, is declining because economically pressed employers have either dropped dependent health insurance, reduced the benefit packages, or required employees to pay a higher premium share for dependent coverage.

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In addition to the payroll tax, the state-administered insurance fund will be financed through federal and state medicaid funds plus premiums and co-payments. For families with incomes below 130% of poverty level, no contribution will be required; for those whose income is between 130 and 200% of poverty level, a sliding scale will be applied.

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3. Case-Managed benefits: Services such as mental health, substance abuse, treatment of developmental and learning disabilities. There will be case management of the benefits in this category.

I have included two pages as a sort of appendix. One is a copy of the state bill and the second, an overview of the national.

EMPLOYER-BASED INSURANCE BENEFIT STRUCTURE

BENEFIT BASKET	SERVICES	COST-SHARING	INDEMNITY LIMIT
PREVENTIVE/ PRIMARY BENEFITS	- PREVENTIVE CARE - PRIMARY CARE FOR NEWBORN	- NO DEDUCTIBLES - NO CO-PAYMENTS	- NONE
MAJOR MEDICAL BENEFITS	- SPECIFIC SERVICES INCLUDING PRIMARY CARE - OTHER HOSPITAL, PHYSICIAN AND DIAGNOSTIC SERVICES	- SAME FOR DEPENDENTS AS EMPLOYEE PLAN - 20 % INDIVIDUAL CO-PAYMENT MAXIMUM - $200 DEDUCTIBLE MAXIMUM	- NONE
CASE MANAGED BENEFITS	- SPECIFIC SERVICES WITH UNPREDICTABLE UTILIZATION (E.G. LONG TERM CARE, MENTAL HEALTH)	- SAME FOR DEPENDENTS AS EMPLOYEE PLAN - COST SHARING AND/OR CASE MANAGEMENT APPLIES	- YES, VARIES BENE-FIT

Substitute House Bill No. 5761

PUBLIC ACT NO. 89-101

AN ACT CONCERNING INSURANCE COVERAGE FOR PREVENTIVE PEDIATRIC CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

(NEW) (a) "Preventive pediatric care" shall mean the periodic review of a child's physical and emotional health from birth through six years of age by or under the supervision of a physician. Such a review shall include a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

(b) Every group hospital or medical expense insurance policy or group hospital or medical service plan contract delivered, issued for delivery or renewed on or after October 1, 1989, shall provide benefits for preventive pediatric care for any child covered by the policy or contract at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen months of age and annually from two to six years of age. Any such policy or contract may provide that services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. Such benefits shall be subject to any policy or contract provisions which apply to other services covered by such policy or contract.

Certified as correct by

_____

Legislative Commissioner.

_____

Clerk of the Senate.

_____

Clerk of the House.

Approved _____ 1989

_____

Governor, State of Connecticut.

Mr. MORRISON. Dr. Krassner, I do have a little bit of a worry about where you are in relation to Panel 2. In many ways, taking care of the children first is an appropriate priority because what happens to them has the most to do in both cost and quality of life terms with the future. But it does disturb me that the pediatricians are off creating their universal program for the children, and not seeing any necessity to say that the whole structure has to change, here is where we are going, and we want to do this first. Do you have a comment on that?

Dr. KRASSNER. Well, first of all, we knew you were going to say that, right?

Mr. MORRISON. I am so obvious.

Dr. KRASSNER. From our point of view, this is not a substitute for, this is a first step in that process. As pediatricians we understand, first of all, the urgency. We have turned our back on children for a long time, and it is about time that as a democratic and thinking and caring society that we do not wait another ten years. We think that it is time to do it now. But by no means is this considered a substitute for. And we are looking at it really, as I said, as a way for maybe working out some of the bugs and some of the problems that could then be applied to a universal health care system.

Mr. MORRISON. I am going to be interested in comments from Dr. Marmor and Dr. Wolfson about this. We had a rather bad experience with, if you will, incrementalism without a goal with the catastrophic health insurance program for seniors on Medicare. It seems to be an example of something that was kind of a square peg in a round hole, and it did not have popular support. It did not really solve the problem that was highest on the list of the people who were going to pay for it, and it really did not advance the cause of getting to a more comprehensive and workable system.

And my question is, is your organization committed to setting some kind of long term frame work into which this fits or not?

Dr. KRASSNER. Yes, it is. We have already contacted groups such AARP who one might have supposed that they would be opposed to this kind of fragmentary inclusion, but they were very happy to see this as a first step. I am close to the Medicare situation myself so that I am not going to cut myself out of this at all, but I think the academy, even though we do focus, we are committed to improving medical care from birth to death.

Dr. STONE. I think the Academy (of Pediatrics) has not taken a position on national health insurance. What it certainly believes in and is committed to is universal access to care. It is also a pragmatic organization, and it knows that children need that care today, not ten years from now. And while national health insurance is, obviously, more comprehensive, how long is it going to take us to get there? And this is something that can be started quickly.

Mr. MORRISON. But I must say that the politics of getting to an appropriate system of universal insurance in the United States is a story of interest group reaction. Take a poll and ask the American people and they buy the Canadian system today. That is the truth of it—80 to 20. The majority is behind a universal access system.

A system was in the Social Security Act proposal in 1935 and was cut out. That distance from 1935 to 1989 can only be explained

by organized political resistance, not by the views of the American people. It is very important that you go beyond saying, "Well, this is a nice piece," and say that it is a piece of something, as opposed to a piece of what we cannot talk about.

Ted, could you comment on how, if you were trying to get from here to there, you think would be the steps to get there?

Dr. MARMOR. Well, you know, I am dumbfounded in a way by the last speaker, because in 1974-75, I advocated kiddie care as the next step to move us along toward the goals of a national health insurance scheme, and treating this as a single step that they had priority in terms of its target group.

And kids had some priority because you could imagine putting it into effect with less of the complexity that would come on with some other groups.

With all the respect and good will I can muster, I feel differently about that in 1989 than I did in 1974. I think we do not have ten years to anticipate getting this system under control. The economic consequences of the overall system, not the medical consequences for children, or particular groups, but the economic consequences of the arrangements we have got are just too staggering. And there is going to be a reaction to it.

So, my thought about getting from here to there would be imagining possibly using this as a step, but only in a scheduled set of steps. I would not see this as an incremental move designed to stabilize for a while while they go on to something else.

I do not expect pediatricians to lead the way on this. They are responding understandably to the pains they see. But I do think it is important for them to hear from others that they should not be the advocates of universalism as the first priority in their concern. It ought to be the second one. That is, they ought to speak candidly your real concerns for doing tomorrow literally yesterday.

But I think, frankly, that what Dr. Wolfson's principles as articulated, would constitute for most pediatric groups that I can think about an acceptable set, at least for the reformers within those groups. It would be very important to leash the plan, in other words, to the principals, and to the staging, and to let the arguments take place as much about the impossibility of continuing to do what we do over all as the special claims of children. That is what I would argue.

Mr. MORRISON. Do you have a comment on the Axelrod plan in New York?

Dr. MARMOR. Well, the Axelrod plan in New York, as I assume you know, is another example of a first step, but it is a first step so to speak on coalescing the payers into one institutional form. It is a very valuable step, I think, for trying to bring together the parties who would have to negotiate with the providers in any kind of expanded scheme that had cost control.

I guess my feeling is that the financing is so out of control at the moment. So much waste takes place in the dollars following the moves as people try to move costs into somebody else's pocket. The axelrod administrative idea is for me a step easier to complete with steps towards national health insurance than any large benefit package increase for any large population group.

I would rather move administratively in the first step to arrange the payers. Hold out the goals that you have set out as the aims for the universal health insurance scheme, and think about children as the target group, if you are going by stages at all, that you would want to start with.

Mr. MORRISON. But can I just—I want to just challenge in a most friendly way your argument that if we are to have national insurance, we must spend more. Much of what we spend now, we ought not to spend. That 1 percent of GNP that distinguishes Canada from the United States on administration alone, does not contribute one whit to our health. I do not want to give credibility to the claim that every dollar we are now spending has an equal claim on our loyalties. It does not. It is the case that those dollars are used for a variety of purposes.

We have to ask, for example, not only whether the service is worthwhile, but whether the price we are paying for it is too much. The new changes proposed in fee reimbursement involve very large shifts between cardiac surgery, for example, and primary benefits.

Not every dollar we are now spending is being done either for the right thing or in the right order. So, I do not think there is magic number of 4 or 5 percent of GNP which is just the right amount of money to start with, but I do agree with you that those principals would involve a very large rearrangement of where the money would go.

Mr. EVANS. Would you—oh, go ahead.

Dr. WOLFSON. Well, I have to confess that while I agree with many of the statements that Ted made, he also made me very uncomfortable in the sense that, as a physician I was sitting next door to a fellow who was giving Canadian physicians none of the credit for the good aspects of the Canadian health care system——

Dr. MARMOR. I will be glad to go into that, and I hope I am asked.

Dr. WOLFSON [continuing]. But for credit for a lot of the bad stuff. The cost increases, and also the individual inefficiency. I think the physicians have to be part of the solution as well. And one of the things that we can bring to the discussion is the knowledge of the problems posed for the delivery of patient care of all of the systems that are out there.

For example, in New York, the Axelrod proposals over the last five years led to a very severe constriction of resources on expenditure personnel and capital development of the New York City hospitals. They failed to allow for the increase in nursing salaries that has appropriately occurred over that time. They failed to allow for the consequences of substance abuse. And they failed to allow for the AIDS epidemic.

Since all of those three major vectors have been manifestively obvious to everybody, there has been no change in the funding available to the New York City hospitals. And efforts have been made to crunch the private institutions to begin spending their endowments in order to make up for this.

The result has been, at least for the short term, agony and a crisis of major proportions in New York City. We need to find out how to do it. Canada has some of the answers. They do not have all the answers. They are shifting patients.

Dr. MARMOR. Why should they have all the answers?

Dr. WOLFSON. No, hut we need to look at them and gain from some of the good aspects, and try to avoid some of the bad aspects. The infrastructure of the Canadian hospital system is in major trouble and is getting worse. And health care costs are rising in Canada. And there is increasing difficulty in the negotiations that you described.

And this is all taking place within the system that evolved over twenty years on a province to province basis, with a lot of change for prospective discussion. And a lot of chance for the society to get together to agree about common goals and interests.

Dr. MARMOR. Could I just answer. It is true that it developed over twenty years, but it is misleading to suggest that each province took twenty years to do it. It happened very rapidly in the provinces You are quite right that there were social decisions to go in that direction. I think the social decisions that you are trying to force attention to, once the social decision was made to go forward, negotiations took place about many of the things you are talking about.

I very much would back the energy and effort you put into treating physicians as major players in the operation of any system, no matter how it is paid for. It is obvious. You cannot have a sensible system without the cooperation of physicians on the care.

But I think a sharp distinction ought to be drawn between pleasing or at least respecting the professional role of physicians as experts in medical care, and the willingness to pay physicians whatever they want. I think on the latter question, there always will be conflict.

And indeed I think there ought to be a sharp division between the professional expertise of doctors about medical care, and their professional expertise about what they ought to be paid. I think they have none in the latter category, and an enormous amount in the former category.

What is interesting, and the point—I really want to highlight this—Canadian physicians, as measured by surveys of their standing in the community, stand higher in their community than do American physicians currently. They suffered less the attacks of the last twenty years on professionalism.

Moreover, Canadian physicians and Canadian hospital administrators have more autonomy about what they do than American doctors, the American hospital administrators, for two reasons:

The budget totals that I talk about that go to the hospitals are not encumbered by lots of details about how to manage the hospital. Canadian cost controllers are very tough on amounts and very flexible on deeds because their interest is making sure that no more gets spent, not on how it is spent. They do not think they have expertise in that.

And on the physician side, I think that we went into this, and indeed what a sensible American state would do would be to investigate each one of these points and get satisfaction on it. What appears to me from my observations of Canadian fee negotiations is great conflict over the total, substantial conflict among some physicians as Canadians have shifted towards care and curative practice and away from cutting and rewards.

The ratio of the top surgeons to the general practitioners has been squeezed over the last 20 years. There has been a lot of complaint in some sectors and not in others.

And finally, there has been in the Canadian medical care area of discretion and autonomy almost no invasion, almost none. Canadian physicians regard the circumstances under which we deal with insurance companies and government payers as violative of their professional autonomy.

And that is the common ground between medical reformers and the Canadian example. Neither to take their view as if it is problem free, how could it be? Nor to take the view that their problems are exactly like ours. They are not. Being better than is important even if it is not the best or the ideal.

So, I am very sensitive to wanting to not hold them up to a standard that they could not possibly meet.

Mr. EVANS. I forgot my question now. It is an interesting debate. First of all, I do want to commend the doctors for being involved in this debate. I am not sure, maybe it is something peculiar to the New Haven area, but many county medical associations have sought to inject themselves than face here, so you are to be commended.

Let me ask, Ted, if he would anticipate increased costs if we would in a relatively short time, adopt something like a Canadian system the way that Dr. Wolfson has indicated with some increased costs because of the numbers of people who suddenly would become eligible for Medicare and start taking advantage of that eligibility

Dr. MARMOR. Well, it would follow as day follows night that if you kept all the same prices and increased the volume considerably, there would have to be more costs. My guess would be that the only way you could avoid very significant increases in cost would be to make no change in the physical capital in any one year. The hospitals would not change.

It is very important that—and let me try to be careful about this—in the hospital sector if we paid on the budget basis, I think we could get away with relatively modest changes because we have got such under use of capacity.

Dr. WOLFSON. It does not apply here. If we do hospitals that are running an average of 105 percent——

Dr. MARMOR. Oh, absolutely. In any areas where there was, you are up to capacity, this would not apply. I am talking about nationwide.

Dr. WOLFSON. Exceeding capacity. We have patients boarding in emergency rooms.

Dr. MARMOR. Fair enough. Those patients need places as far as the nursing supply goes.

Mr. MORRISON. Part of that is the nursing supply.

Dr. WOLFSON. Right. And then the hospital cost commission.

Mr. MORRISON. I think we have closed wards because of closed rooms because of lack of nurses.

Dr. MARMOR. But you see what I am driving at. In the area where we got ⅔ occupancy rates, there is excess capacity. On the other hand, if you paid by case, it would not apply, right? So, there is the economics of increased costs. The hospital should not have,

on average over the whole country, any great increase in physical capacity required. Overall, the whole country.

If we have ⅔ capacity now, it cannot be the case overall.

Mr. MORRISON. But the capacity is sometimes in the wrong places.

Dr. MARMOR. Exactly.

Mr. MORRISON. We may have to pay twice. You are going to pay to close units down, and you are going to pay to open units up.

I think we should be careful. I think it is a real good point we cannot promise the American people we can do it for nothing. We have a President who has done that, and we know where it has gotten us. If we do that, we will never get down the road, and it will all blow up in our faces

Dr. KRASSNER. They did not cut the quality either. I mean, if you are going to cut down the amount paid for a service, and then you are going to put it out there for the doctors, they are going to increase their volume. So, instead of spending twenty minutes with a patient, you will spend fifteen minutes with a patient to keep your income where it is.

Dr. MARMOR. That very much applies. In the short run in Canada what happened in the first years of putting it into effect, first physician incomes went up sharply. And one reason physician incomes went up sharply is that they had no bad debt in the year X plus 1. That actually—there is a case where you are going to have an increase.

Second, it went up because it was all reported. So reported income went up. There were big changes in Quebec, like 55 percent, which was not all new dollars. So, that will be relevant.

And, thirdly, it went up less than it would have because the provinces paid at fee levels. They took into account the bad debt and paid the first year at a reduced amount from the fee schedules that were negotiated, saying that the fee schedules earlier had incorporated a bad debt. And that over time, a lot of struggles took place.

But I think the short answer to your question is, there is no way to move to an expanded utilization nationwide without some increase in outlays in the first year. No way. But that the Canadian example does illustrate that you can maintain those outlays over time, or even reduce them somewhat as you reallocate within medical care. I think that is the answer I would give.

Mr. EVANS. The devil's advocate question. The spread of the AIDS problem now largely in our country, I am not sure it is true in Canada, is being caused now by the use of needles by drug users and so forth, does that make it still similar to Canada? I realize that is going have an impact whether we change from one system or another. But that is a real problem that we are going to have to deal with, as is the crack problems, and the problems it is having on our delivery in medical service here. We will have an impact one way or another. But was that going to cause a big disruption in terms of if we would switch?

Dr. MARMOR. I do not think so. I do not think the switch of financing, or the change in negotiation about budgets or fees is the basic problem. The basic problem is generating the resources and

channeling them appropriately to people who have this particular set of physical ailments.

And Canada has exactly the same mix of troubles, but not the same magnitude of the troubles. They do not—in other words, AIDS for them, there is not a lot of discussion of the financing problem of AIDS. There is a lot of discussion about the financing problem of medical care. There is a lot of discussion about what physicians ought to be paid. Not what they ought to be paid for AIDS victims.

It does not—it is fascinating, in the Canadian context there is almost no discussion about the aging and graying of the society as if the elderly are a special group that we have to worry about because we are having more of them. There are lots of disputes about whether we can raise the money to pay for medical care, and then it goes to the citizens we have. You do not change the grain of the budget.

So, as in the case of these special populations, the fights are about the basic economics, and about the quality of care, whether it is threatened or not by the base of economics, and about who ought to pay. That is not only the funding amounts, but the sources of funding, should it be premiums or general revenue. It is hardly ever about these disputed population groups, as you were suggesting.

There are disputes about AIDS, but they are not medical. They are not given their home—they do not become a fragment of the discussion of the special funding.

Dr. WOLFSON. Part of the problem about talking about costs is that in every system that we looked at, costs were shoved around. For example, in systems that economize on health care by delaying elective surgical procedures, there is an enormous societal cost involved there.

If the wait is a year for a hip replacement, that is a year during which that person is withdrawn from the work force. And he and she and the family suffer and have to draw on other societal resources and are non-contributing members of society during that period of time.

We heard a lecture at the Yale New Haven hospital earlier this last week from a British cardiac surgeon, who pointed out the fact that he had not done an elective cardiac surgical procedure in two years, the average wait for cardiac surgical procedures in that country being eighteen months if they were on an elective basis. He was doing nothing but emergency cardiac procedures because by the time the patients were arriving on his operating room table, they were critically ill and emergent. He was doing most of the surgery at night and on weekends. The man was very pale and very tired.

Mr. EVANS. I guess I would like to conclude with maybe two observations about Congress because that is part of this debate.

One, I am afraid that some of my colleagues in Congress will view the repeal of catastrophic health care as a way of saying that any further involvement by the Federal government in health care areas are probably not good at this time, given the reaction of yourself and some of the senior citizen's organizations.

And, secondly, I am a member of the Armed Services Committee, and I am very much in favor of allowing some of this money that I think we have been wasting. I think Bruce and I are very similarly minded on this backing so many different areas of our economy that have been neglected.

But the administration talks on one hand of a 2 percent decrease. What they are really talking about is a 2 percent decrease in the planned increases. And it is very hard to understand what that means. But they really have not talked about any substantial withdrawal of the nearly 300,000 Armed Forces personnel from the NATO countries. And that is about all the progress we have seen.

So, do not spend that piece yet. I would like to spend it before some of these have occurred, but that is going to be a battle, I think, that Congressman Morrison and I will be fighting together to bring some of that money back home.

Dr. KRASSNER. The fact of this discussion points out though that this is a very complicated problem, and our approach, I think, would be a very simple way to at least move off dead center and give some momentum in that direction while this discussion is going on because—I have never been known as being a pessimist, but I cannot see that we are going to move as fast within a year or two or three or four. I think it is going to be longer.

Mr. MORRISON. Although that observation truly astounds me, I do not know of any other issue in our current public debate where the log jam of our political system is as far from the position of the American people.

It has gotten to the point where you have the Lee Iacoccos of the world essentially for national health insurance at a time when you have liberal Democrats saying it cannot be done. This is really quite bizarre. And that is—somehow we ought to break through that.

It really does seem to me to be the ultimate example of where PAC financing politics has left us unable to see the forest for the trees. that we just cannot imagine telling the AMA, and HIAA, and IAC and all these folks that the game is over, that now, it is going to be a very different system, and if you want to be a part of it, you are going to have to accept some different premises about where we are going.

So we must all get together before we wreck the whole system, because we are going to tear it apart or make a lot of the same mistakes that were made in 1965 because of who made what decisions and who would not play.

If you think about Catastrophic, there are two things you should think about. One, is that it all turned into a disaster. But the other thing that is interesting is that a popular position sort of swept away all in its path, and people just finally said, "Enough already! We want X."

If there were a breakthrough of corporations, doctors that are fed up with the system that does not work, and patients who feel that the current system does not respond to their needs, and they were as organized, as the people who were against Catastrophic, this political debate would be very different and would move a lot faster. And it is a little bit of our own limitation of vision that is keeping this from happening.

Dr. MARMOR. Could I try to link that up with the Canadian experience in this way? In the middle 1960s it was assumed in Canada as well that they were a long way off from changing toward physician insurance. People assumed that the Canadian Medical Association would fight like tigers about it; and, of course, they did. And they would object to it.

A commission was set up, headed by Justice Hall, which went all over the country and got groups discussing this all over Canada. And to everybody's surprise, this conservative former Chief Justice of the province of Saskatchewan and his whole commission came out with some physician support to move ahead. And the barriers fell rather quickly.

Nobody predicted this outcome. And in the same way, I think, as we have been astounded by eastern Europe in the last six months, people have been astounded by the change in the corporate attitudes in the United States. This is an unprecedented set of arrangements.

Mr. MORRISON. But there is no evidence that Jay Rockefeller's commission, formerly Senator Pepper's commission, is going this way, nor is there any indication that the Blue Ribbon Commission in Connecticut is really moving towards that.

I wanted to ask one more question, Ted, and that is: you mentioned that Canada had a Blue Cross type of health insurance financing system before. What was that transition like, and what role did Blue Cross play in that, and—do they still exist in some form?

Dr. MARMOR. Yes, they do.

Mr. MORRISON. What form do they exist in and what does that mean?

Dr. MARMOR. I think what was found in the 1950s as employer-based insurance coverage spread in Canada just the way it did in the United States is that they thought they were reaching, in the provinces of Canada, a natural limit to the employer-based extension—about 75 percent of the population. For the rest you ran into small firms, unattached individuals, exactly the problems that we are dealing with. And the suggestion was that you could not make it universal. You could not get private health insurance to cover everybody through any conventional market-like operations. You would have to produce substantial subsidies to add on to Blue Cross if you were to do it that way, or you would have to replace it.

The feeling was, as well, that Blue Cross was then starting to compete with commercial carriers for hospital insurance and giving up its community rating and adopting an experience-rating scheme that would over time, produce more and more variations in the expenditures for hospital care.

So, the conclusion was drawn that if you really believed equal access to this care was important, you would never get it by the normal operations of the insurance market. Because even if you got universal coverage of some hospital care, as long as you had experience rating, it would start introducing variations in the premiums; and, in effect, create uncovered groups.

Result. The national legislature in 1957 proposed a scheme whereby as soon as 5 provinces had a universal scheme within their province, they would do it for any province. And that happened in be-

tween 1957 and 1961. They got a 5, and as soon as 5 did it and the government was willing to pay half the costs, you can imagine the others came in quickly.

The same process happened really in medical insurance. Now, what are the common features about both these? They expanded by type of service. We expanded by type of population. After all, in these twenty years we have not been uninvolved in the medical care sector with the government. We have been expanding by groups. They were expanding universally for activities.

During that time, their equivalent provided sponsored insurance schemes—Blue Cross/Blue Shield. They had different terms for it—Trans Canada. And their insurance competitors fought like crazy against the expansion of universal health insurance. No question. There is never an instance that they came around. I think the hope that they will is a vain one on the basis of the Canadian experience.

Secondly, the terms of Canadian national health insurance are that a private health insurance, a non-government health insurance cannot be sold for the same benefits that the public plan covers. In other words, you cannot have a supplementary plan for better hospitalization. Or a supplementary plan to cover the fees above the fee schedule for very good reasons because they did not want—you can imagine why not.

On the other hand, Blue Cross and Blue Shield equivalents in Canada discovered that their relations with employer groups gave them an in on the expansion of fringe benefits when health insurance dropped out of the fringe benefit world and shifted into the social insurance world.

What I mean is that the fixed cost of reaching every major employer in Canada had already been paid by all the insurance companies. When you took one of their market items out, which they opposed, it turned out that they had a lot of other things to sell. They sold dental insurance. They sold disability insurance. They sold special retirement coverage and a variety of schemes. And they are, in fact, quite a healthy lot.

Point. Opposition throughout the period of discussion.

Result afterwards. Expansion into other markets, and they did not prove to be a decisive element in the political acceptability.

Mr. MORRISON. I want to thank you all. I thank you for your patience to stay and be the last panel. But I think it is important that you be the last panel because somewhere among the alternatives lies the answer. That is clear. Whether we can agree on them, that is another question. But we thank you very much, and the hearing will stand adjourned.

[Whereupon, at 1:40 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record:]

PREPARED STATEMENT OF THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING REPUBLICAN MEMBER

The title of this hearing, "The Changing Face of Health Care: The Movement Toward Universal Access," masks an uncertainty about what is at stake and presumes a consensus which has not materialized. There seems to be a blurring and jumbling together of issues which have separate purposes. Before embarking on a path assumed by the title of the hearing, let us illuminate some of these issues.

First, let us acknowledge that a federal role in providing access to health care is nearly as old as the republic itself. The federal government has been providing health care since 1798. Today, 54 million Americans, or 22 percent of our total population, receive their "health insurance" coverage through federal programs. Of the $487 billion spent on health services and supplies in 1987, over 40 percent was distributed through government programs. Moreover, we have witnessed a tremendous shift in the burden of payment since 1965, generally away from the individual, as the following table shows:

DISTRIBUTION OF HEALTH SERVICES EXPENDITURES BY TYPE OF PAYER

Type of payer	Percentage of expenditures	
	1965	1987
Federal Government	10.9	16.2
State and local government	11.5	13.7
Business	17.4	27.9
Household and philanthropy	60.2	[1] 42.2

[1] Katharine R. Levit, Mark S. Freeland, and Daniel R. Waldo, "Health Spending and Ability to Pay: Business, Individuals, and Government," Health Care Financing Review. U.S. Government Printing Office. Spring 1989. Vol. 10 No.3. p. 7.

At any given point, it is estimated that 7 out of 8 Americans are insured: 22% by Federal plans, 54% by employer group plans, and 9% by private individual insurance.

Next, let us directly ask, what is the purpose of proposed reform? This is a critical question, as would-be reformers offer different rationales for change. After considering all of the testimony, I am uncertain of the central issue about which reformers think we should be most concerned. Is the purpose to control health care costs? Is it to shift public subsidies to redress preceived inequities? Or, is the purpose to provide necessary medical care to individuals who are not receiving the care they need?

Let us untangle this confusion and consider each issue.

Is the purpose to control health care costs? Everyone has a stake in slowing the growth in health care expenses. Business has seen health spending triple since 1965 as a share of total labor compensation.[2] Although individual health spending as a share of adjusted personal income was unchanged over 15 years between 1965 and 1980, consuming 4.1 percent in each of those years, this percentage increased over 7 years to 5.5 percent by 1987.[3] Health spending as a share of total receipts has tripled for the federal government and nearly doubled for the state and local governments. The federal government now spends 13.9 percent of its revenue on health care, compared with 11.4 percent in 1980, 11.3 percent in 1975, 7.2 percent in 1970 and 4.2 percent in 1965.[4]

A shift to the Canadian system as the means to control costs, as some reformers have recommended, may be a "cure" which is worse than the disease. At first glance, we find that Canadians seem to pay less for health care, at least in terms of health care as a percentage of GNP. In 1987, health spending in Canada was an estimated 8.6% of GNP compared to about 11.2% here.

In the debate over health care, cost is widely understood but value is ignored. Here we find the cracks in the facade of Canadian health care delivery. Canada, as in other countries with state-run health systems, must ration care as a finite commodity. Thus, promises are not equal to performance. Access to care is therefore not free and easy, unlike what U.S. admirers would have us believe. Waiting lists for a panoply of surgical procedures have become an increasingly common fact of life across Canada. Resources allocated by central planning result in too many empty hospital beds in one area, and too little in another. There are limits on where and how physicians may practice. There have been strikes by the country's unionized doctors. On a province-by-province basis, health care costs are going up even as Canada's ailing economy is forced into more austere measures. "Queuing for care" is becoming a common expression in Canada as citizens are introduced to the restrictive nature of a rationed, tightly managed government system.

Next, we should consider whether the issue is not really about health care, but rather that is about providing subsidies to a new population to redress perceived

[2] Ibid., p. 8.
[3] ———. p. 10.
[4] ———. p. 10.

inequities. A great deal of public attention has been directed t· a significant number of Americans who do not have health insurance. This moves us to inquire, "who are the "uninsured?"

Approximately 15 percent of Americans are uninsured, but only 1 in 7 have no workforce attachment. To state this perhaps more precisely, 70 percent of uninsured adults are in the labor force. In half of the uninsured families, the head of the household is employed on a full-time, full-year basis. However, most are uninsured only temporarily.

Roughly 1 in 3 of the uninsured are children. This is a very critical point to policy-makers in general and the Select Committee in particular. The search for a solution leads us beyond the issue of health care. We find, once again, that we cannot separate the status of the child from what happens within the home. Children living with only one parent are twice as likely to be uninsured as children in two-parent families. While 20 percent of adolescents living with just one parent are uninsured, only 10.7 percent of adolescents who are living with both parents have no health insurance coverage. Parental employment is definitely a key to health insurance status for children. Only 9.5 percent of adolescents who have a full-year, full-time working parent lack health insurance coverage.

It is also misleading to assume that all uninsured children are poor. The Office of Technology Assessment has found that:

"Despite the strong relationship between low family income and the likelihood of being uninsured, it should be recognized that for adolescents, as for adults, it is by no means true that all the uninsured are poor. While 41 percent of uninsured adolescents live below the Federal poverty level one-third of uninsured adolescents are between 100 and 199 percent of poverty, and more than one-quarter are at 200 percent of poverty or above." [5]

There may be some concern about equity in the present health care system. But we must carefully consider the impact on our welfare system as well as the health care system before extending new subsidies. Do we wish to extend new subsidies to the non-poor? If we decide that we should, do we need to shatter the entire health care system to do so, as some reformers would have us in adopting the Canadian system?

Finally, if we assume the purpose of reform is truly about providing necessary medical care to those most in need of services, then the Committee should consider a strategy different from than those presented at this hearing. There is very little explanation of how these proposals will result in improvement in our health status. There is no mention of our public health system which includes more than 3,000 local health departments nationwide. And much of the work in public health is devoted to the very population targeted by the rhetoric—pregnant women and children under the age of 6. Are we to simply abandon this vast system?

The effective provision of medical services is what reform should be about. We need to shift our emphasis from process to client outcomes. In other words, our real concern should be, "why are we not finding better results for the public resources we are already spending?" Between 1977 and 1987, health care spending on behalf of children virtually tripled ($19.5 billion to $52 billion); in the same period, per capita health spending for children 19 and under jumped 177 percent. Yet, for all the spending, the results are a disappointment: infant mortality remains unacceptably high, low birthweight rates have not changed for several years, basic immunization rates against childhood diseases are low among young children, and we will fail to meet many of the national health objectives which were established for 1990.

Clearly, something has gone awry in how public policy has been crafted and implemented on health care delivery. Despite our good intentions, we have established a maze of programs that by nature make it frustrating and difficult for the needs to take full advantage.

In the case of health care delivery, we are finding more widespread agreement that serious changes are needed in this country. Within that context, however, I strongly advise my colleagues not to expect an instant solution, a magic wand, from north of the border.

Let us instead fill the gaps in the existing public health system. I have introduced the Consolidated Maternal and Child Health Services Act (H.R. 2881) which recognizes that the incremental, categorical program approach to health care management is a barrier, not a gateway. Under this proposal, the emphasis on health out-

[5] U.S. Congress. Office of Technology Assessment. "Adolescent Health Insurance Status: Analyses of Trends in Coverage and Preliminary Estimates of the Effects of an Employer Mandate and Medicaid Expansion on the Uninsured—Background Paper." Washington D.C.: U.S. Congress, Office of Technology Assessment, July 1989. OTA-BP-H-56. p. 5.

comes would enhance the abilities of the states and localities to meet their respective needs. It would also help to control the runaway administrative costs which have plagued every level of the delivery system.

Change is necessary. But let us be quite certain about where we want to go.

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